Resolution and Reunification

A Step-by-Step Guide for Therapists Treating Youthful Sexual Offenders

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Introduction

The reunification of sexual abuse victims, offenders, and families is one of the most complex treatment concepts. Despite this complexity, it remains one of the most important treatment techniques. In researching the concept of reunification of sexual abuse victims, offenders, and families it is clear that there is no concise model to direct the work. Therefore the goal of this book is to create a model or step-by-step guide to reunification.

It must be understood, however, that reunification is not a standalone concept. Successful reunification is based upon other prerequisite concepts. Because reunification is contingent upon other concepts, the treatment approach must expand from a reunification model to a resolution/reunification model. This indicates the dependence of successful reunification upon other prerequisite treatment techniques.

The prerequisites for reunification are based upon a 6-phase model. They are: 1) preparation and goal-setting; 2) clarification of abuse dynamics and issues; 3) resolution of abuse dynamics and issues; 4) reintegration of the offender with the family, community, and social group; 5) reconciliation and reunification of families; and finally 6) closure of the abuse. The intent of this book is to outline the foundational concepts, philosophies, and guidelines to facilitate resolution/reunification services, while presenting each phase with its corresponding goals, benefits, and tasks. The book provides a step-by-step guide for the clarification, resolution, reconciliation, and reunification of youthful sexual offenders with those they have harmed and, most importantly, minimizing the impact of sexual abuse for all involved.

This book is primarily intended for therapists working with youth with sexual behavioral problems; however, it may be used as a guide for therapists treating victims of sexual abuse. The resolution/reunification model supports a parallel treatment process indicating the treatment of youthful sexual offenders and their victims can be accomplished through a parallel/connected process. This process recognizes that there are connection points in treatment of both the offender and victim that allow for clinically facilitated communication that is clinically beneficial to both. Each phase identifies these connection points and develops clinical tasks to be communicated. Through this process the goals of each phase are accomplished.

It is apparent that a resolution/reunification model must be sensitive to the population it serves. This model is intended only for children and adolescents who have committed sexually inappropriate behaviors. Additionally, the majority of victims of youthful offenders are themselves children. As a result all attempts have been made to ensure that the model and steps are sensitive to the nature of youth. Most youthful offenders select victims based on access; therefore the offender and victim are often within the same family either immediate or extended. This model is sensitive to the unique dynamics of intrafamilial abuse and works to facilitate healing and reunification of these families.

Inherent in resolution/reunification are difficult questions that must be resolved prior to commencing services. These difficult questions, as well as the answers to them, will be identified.

It must be noted that there are times when reunification is contraindicated. The criteria upon which resolution/reunification services should not occur, be postponed, or stopped are also included in this book.

Preparation of resolution/reunification participants is critical to success. The criterion for preparing participants will be presented for each phase.

Author's Note: When discussing sexual abuse, the language one uses needs to be sensitive. Every attempt should be made to select language that avoids the labeling, stigma, or vilification of youth. However, the model of resolution and reunification, requires accurate identification of the participants. The following references are for clarity of role only, and in no way intends to perpetuate the stigma or to label youth as sexual offenders; it is simply the best way to define the roles within the process. Therefore, those who have chosen to engage in sexual misconduct will be referred to as the *offender*, those directly harmed by the act will be referred to as the *victims*, and those indirectly harmed by the act will be referred to as *other participants*. Additionally, the main focus of this book is children and adolescents. Therefore, the term *sexual offenders* refers only to *youthful* offenders. Finally, when the term services or intervention is used it refers to *resolution and reunification* services.

Chapter One

Resolution and Reunification

The sexual abuse of children by children and adolescents remains a significant problem and concern for society. Sexual victimization can be one of the most difficult experiences possible. The effect upon those involved may be traumatic and at times devastating. Sadly, it is estimated that sexual abuse will impact 27% of all females (about one out of every four), and 16% of males (one out of every six) (Finkelhor, Hotaling, Lewis, and Smith, 2002, p. 19). Sexual abuse occurs in every race, culture, community, and socioeconomic level. As Yantzi (1998) stated, sexual abuse "impacts our community and society like ripples breaking the water's smooth surface" (p. 54).

The expanding ripples of abuse may affect all they touch, and each life touched is harmed (to a greater or lesser extent). So often, in viewing the influence of sexual abuse, only the offender and victim are considered. However, it is clear that the ripple effect of abuse has a much wider influence. Not only the victims, but their families (both immediate and extended), peers, neighbors, and communities are affected.

Communities are responsible to create interventions that protect individuals from experiencing abuse as well as help individuals ameliorate the trauma of abuse once experienced. In the 1980s, communities began to confront the reality that youth were committing sexual offenses. This awareness prompted the creation of treatment interventions and strategies dealing with sexual abuse perpetrated by youth. Amazing strides have been made in this process. In almost every community, treatment is available for youth with sexually-abusive tendencies. Also, due to the nature of the ripple effect, strides have been made in the creation of treatment models and services for all those directly impacted by the abuse.

The dynamics of sexual abuse may change or destroy the families that experience them. Professionals have recognized this and have understood the need to heal and reunify these families. As a result, the resolution of sexual abuse within the entire family has been an integral part of the treatment of sexual abuse from the beginning.

In time, recognition grew that any attempt to help offenders, victims, and families resolve the impact of sexual abuse was a complex and complicated issue. Successful resolution required addressing multiple complexities within the circle of abuse. It is perhaps the most difficult and potentially risky treatment task required of clinicians because it creates potential for additional trauma. The fact that sexual abuse is a highly-charged and emotional issue within society complicates the matter. All of this has combined to make resolving the impact of sexual abuse a very complicated, complex, and challenging task.

Despite the complexity of the treatment issues, most families desire successful resolution of their situations. This requires clinicians to be adequately informed and continually updated on the latest methods of treatment in order to successfully resolve familial sexual abuse. However, when looking at the current professional field, there is no clear empirically-based philosophy or treatment practice guiding this process. It is no wonder that many professionals are hesitant to reunify youthful sexual offenders with those they have harmed. The standard for resolution of sexual abuse issues and reunification of families currently does not exist. This book is an attempt to rectify this by presenting a model to guide practice.

The resolution/reunification of sexual abuse relies on the following key elements.

1. **Clarifying of abuse issues and impact**
   Clarification is a procedure that promotes clinically-facilitated communication between the offender, victim, family, and others impacted. The intent of this communication is to clarify the abuse experience, as well as the resulting issues and dynamics.
2. **Resolution**
   Resolution separates issues into problems and questions, while creating a plan to solve, clear up, or settle those problems.
3. **Reconciliation**
   Reconciliation is restoring all impacted (including the offender), to union and friendship by bringing all to agreement or returning to health.
4. **Reintegration of the offender**
   Reintegration is a process of gradual re-acclimation or adjustment to a non-supervised, less-structured environment featuring opportunities to demonstrate new social skills and responsible decision-making in support of community and personal safety.
5. **Reunification**
   Reunification is a clinically-facilitated step-by-step process that is designed to reunify victims, and families (both immediate and extended), who have been harmed by the experience of sexual abuse. It is the systematic restoration of relationships leading to reconciliation and reuniting of families.
6. **Closure**
   Closure refers to helping participants move past the abuse experience into a greater here-and-now focus, helping them acknowledge the abuse as *one part* rather than the *main focus* of their life. It indicates that individuals no longer view themselves, their life, or the world through the abuse.

There are six phases which define and provide a structured approach to resolution and reunification. Each phase defines a specific goal of the process which then identifies possible tasks and communication points.

The first phase is a preparatory phase in which professional commitment and collaboration is established to prepare participants, make decisions, and create a clinical forum.

The second phase focuses on the clarification of abuse issues and dynamics. It is designed to provide participants with the knowledge they need to identify and understand the sexual abuse.

The third phase helps participants heal the trauma of the abuse by facilitating communication between the youthful sexual offender and victims. This is the resolution/reconciliation phase and it is designed to resolve issues and trauma of the abuse while reconciling individual and family issues.

The fourth phase helps offenders reintegrate into their family, peer group, support system, and community.

Phase five works to reunify offenders, victims, and families.

The sixth and final phase aids all participants to let go of the abuse and bring closure to the abuse experience.

Although each phase is considered as a distinct period within the process, successful resolution/reunification is based upon the unique needs and desires of its participants. As a result, flexibility is encouraged in all phases which enables both professionals and participants to view resolution and reunification as a continuum with connectivity within the phases. Phases do not require that a step be totally completed prior to moving to the next step. Decisions and choices by professionals and participants should be made at each phase to determine the tasks and progression of the process. This allows each case to be driven by its individual nature, thus resulting in an individualized conclusion.

There is a continuum of possible successful outcomes for participants. However, it must be recognized that specific tasks require prerequisite work. For example, reunification cannot occur without resolution and reconciliation, and in turn resolution and reconciliation cannot occur without clarification. Although resolution and reunification of sexual-abuse participants is flexible in nature, it cannot be taken lightly. It must be approached in a gradual and careful manner, ensuring that a safe and healthy foundation of individual healing is achieved prior to moving into more complicated areas.

These phases and steps are a beginning response to the complexity of sexual abuse treatment. It is a starting point. It should be considered dynamic in nature. Hopefully, the model will continue to improve as new ideas, techniques, and methods, coupled with empirical data, and practical experience present themselves.

Successful resolution and reunification must be anchored to correct foundational values, concepts, and philosophies. These define the parameters upon which treatment services are built and delivered. All phases and steps of treatment services should be governed and administered by core values and guiding philosophies. Below are the core values and guiding philosophies that are adopted in this model of resolution/reunification services.

Core Values and Guiding Philosophies

Intervention Must be Specialized

Sexual abuse is a unique problem infused with complicated dynamics. Treatment requires a highly-specialized form of mental health intervention. This specialized approach requires specific training, theories, intervention, techniques, and clinical practices on the part of therapists, legal professionals, and supervisory systems.

Treatment of sexual-abuse issues must be conducted by trained and skilled professionals. In fact, Ward, Polaschek, and Beech (2006) indicated that because of the qualitative differences in treatment of sexual offenders vs. general psychotherapy clients, a "need for a high level of therapist's skills is paramount" (p. 324). Due to the complexity and the possible risk of exposing victims to further harm, all resolution and reunification services must be undertaken, conducted, and supervised by professionals skilled in working with sexual-abuse dynamics. Additionally, professionals should have advanced knowledge of child and adolescent development, understand the impact of contextual issues upon said development, be aware of the complexities of sibling incest and intrafamilial abuse, and be fully cognizant of the risks of these services. Professionals must also have a clear understanding of the best practice in treating victims, offenders, and families, and facilitating resolution of abuse issues and reunification.

Intervention Must be Clinically-Facilitated, Driven, Structured, and Supervised

Resolution and reunification requires cautious clinical planning. This means that all steps are clinically driven with clearly identified needs, purposes, and goals. Services must also be implemented in a gradual and deliberate manner.

Resolution/reunification services should also be clinically structured and supervised. Professionals must establish an environment that is therapeutic and safe for all participants. Appropriate rules and safeguards should be established during all phases, as to prevent re-offense, maltreatment, and harm to any person, while ensuring maximum therapeutic gain for all participants.

External control of the offender is essential. This control will ideally be provided by a supervisory team composed of a legal agent such as a probation/parole officer, or caseworker, and will also include the clinician and the legal guardian or caregiver. This external control is designed to supervise the offender's compliance with legal rules and expectations, treatment participation, rules at home or in placement, school attendance and participation, and all safety considerations and plans. Those providing the external control must be trained to hold the offender accountable and assign consequences for non-compliance. This also means that if the offender's risk issues increase, then reassessment of placement and treatment intensity must occur, as will a determination of whether resolution/reunification services should continue.

Due to the nature of sibling incest or intrafamilial abuse and the desire and pressure to reunify, often families and victims can make decisions that are not in the best interests of participants. As a result, professionals need to supervise and provide protection against decisions, communication, interaction, or contact that is inadvisable or harmful.

Finally, it is recommended that resolution/reunification interventions should occur while the offender is still under supervision of the legal system, is participating in treatment, and under court jurisdiction. The intent of this is to ensure external control of the youth. If the offender is not under legal interventions the process may still work if external control is placed with a professional who is capable of ensuring compliance to the safety plan and goals each phase.

Intervention Must be Based on an Individualized Approach

The impact and trauma of sexual abuse is experienced and expressed individually. Healing requires the same type of approach. All resolution and reunification services must be based upon and driven by the needs of the individual participant(s).

Sexual offenders and victims are often treated in isolation with limited or no contact. This is not what is meant by an individualized approach. An individualized approach indicates that each participant's clinical needs are identified, valued, and treated. Each participant retains the right to determine the course of his/her participation. It helps each participant to achieve his/her clinical needs and to benefit from this participation. This supports a varied process that can lead to multiple closure pathways.

Treatment services seek to create a collaborative forum for resolution and reunification to occur, but does not overlook the individual needs of each participant.

Treatment services must be tailored to the best interests of each participant. This means that services are not a 'one size fits all' process. The phases, goals, and tasks need to be adapted to individual participants.

It is critical that all interventions be anchored in the clinical needs of participants ensuring the clinical necessity of all phases, interactions, and tasks. Above all, interventions must be based on the individual's willingness to participate, his or her desires regarding services, his or her individual needs and necessities, and healthy individual motives. Each participant should

understand that he or she directs the course of services, its tasks, interactions, and point of closure. Each participant can also clearly identify how services benefit him or her and that participation is in his or her best interest.

Supervision and legal programs administering interventions should clearly understand that resolution and reunification must be individualized to the participants. However, in adapting interventions to the individual participants, individual and community safety is paramount. As Bengis et al (1999) wrote, a therapeutic program must "provide for the individual rights of the residents it serves in a manner that does not conflict with the responsibility to maximize community safety, protect past victims from further harm, and yet still produce a positive treatment outcome" (p. 17). It is important to ensure that individual needs or rights do not supersede safety concerns.

Intervention Must Include a Parallel Treatment Process Defined by Clinically-Facilitated Communication

Therapists should recognize that there are similarities in the treatment of youthful sexual offenders and victims of sexual abuse. These commonalties can create a parallel treatment process that facilitates interaction and communication that is healing for both. Recognition of a parallel treatment process allows professionals to bring together youthful sexual offenders and those they impacted in a clinically-facilitated communication that increases the success of resolution and healing. The revised report from the National Task Force on Juvenile Sexual Offending (1993) asserts that interaction with the perpetrator "can enable victims to purposefully explore their feelings and thoughts that resulted from their abuse in an atmosphere that is supportive of their recovery process. Such contact can help to depersonalize the act and personalize the abusive dynamics which shifts responsibility to the abuser and decreases the victim's erroneous self-blaming. Such contact can also provide a sense of reality testing which validates the victim's experience, and provides a safe place for the victim's expression of pain, anger, rage, fears, and sadness which may otherwise be suppressed" (p. 72).

The parallel treatment process creates communication points where victims and offenders interact and communicate over a specific treatment assignment or goal. This communication facilitates the achievement of the goal in a more effective way. For example, many victims struggle to eliminate misattributions of their own responsibility for the abuse, while offenders struggle to own responsibility for commission of the offense. This parallel treatment process creates the opportunity for both to address and correct this issue.

Clinically-facilitated communication is founded on the belief that the extent, frequency, and quality of interaction or communication is based upon the relationship, degree of intimacy, desire for future relationship, and contact between the offender and the victim. This belief should be used in determining the extent of all communication. The closer or more intimate the relationship, the higher the potential for frequency of contact, and the higher the possibility of continued relationship or interaction; thus, there would be a higher need for more in-depth, facilitated communication.

The parallel treatment process advocates for clinically-facilitated communication between youthful sexual offenders and victims. The parallel treatment philosophy indicates that:

1) Treatment of offenders and victims run along parallel lines, with commonality of treatment goals.

2) Commonality of treatment goals creates clinical opportunities for interaction that facilitates healing for both participants.

3) Interaction and communication are healing for both the victim and the offender, and
4) Interaction can help accomplish treatment goals quicker and more effectively.

Intervention Must Involve All Impacted

All individuals impacted by the abuse should be offered the opportunity to participate in the services in a meaningful way. All participants -- offenders, victims, families, and all others impacted – have a right to heal, be heard, have a say, and be given the opportunity to exercise those rights. Treatment plans should allow for the creation of goals and tasks for each participant. Successful resolution and reunification is dependent upon each participant's completion of tasks. It must also be emphasized that all goals and practices should be designed for the benefit of all participants.

Intervention Must be Victim Driven and Sensitive

Often in sexual-abuse cases, the identified victim is a child, and as a result, needs help in feeling safe and in understanding the goals of the treatment services and his/her own desires. Therefore, all treatment practices must be victim-sensitive and victim-driven. This indicates, that the "needs, values, safety, and rights of the victim come first and foremost" (NAPN, 1993, p. 72). The desires, wishes, and concerns of victims drive any and all interaction, communication, and/or resolution and reunification services. It must be remembered that after the abuse, victims often feel "vulnerable and powerless" (Umbriet. M, and Greenwood J, 2000, p. 2). As a result of these feelings, all services must assume that victims are in a vulnerable state and if not protected, resolution and reunification services can further traumatize.

The victim's perception of the justice system must be understood. The current justice system is often offender-focused. Often the victim is "excluded from the process rarely being offered an opportunity to tell his or her experiences, define the resulting harm or express needs" (Umbriet. M, Greenwood J, (2000, p. 2). As a result, victims of abuse are often not given the attention they deserve within the many social, treatment, and justice systems. This experience may contribute to victims feeling powerless or unheard, or that their desires, rights, needs, and wishes are unimportant. It is therefore critical that, during all services, victims feel empowered by their participation.

To ensure resolution/reunification services are victim-sensitive and victim-driven, focused on empowering victims, the following guidelines are offered.

1. Control
   Victims must retain a sense of control over the process, its communications, interactions, and interventions.
2. Safety
   The safety and well-being of the victim must be the primary focus in all interventions.
3. Attention
   It is critical that the victim feels heard, feels part of, and is given the attention and services they need to heal.
4. Have a say
   Victims must have a say in the rules, safety planning, and parameters governing the offender.
5. Respected
   The victim must feel that their wishes, desires, and decisions will be respected and adhered to by the offender.

6. Choices
   The victim must feel that they have choices and options within the process.
7. Speak Safely
   Above all, professionals should work to create a forum in which victims can "speak safely about their experiences and potential concerns" (Center for Sex Offender Management, 2005, p. 3).

Intervention Must be Accountable and Responsible

All professionals and participants must be accountable to each other, to individual and community safety, and to the integrity of the process. Participants have the accountability to clarify and voice their needs, desires, fears, concerns, and issues throughout each part of the process.

It should be remembered that often the victims and the offenders may not clearly understand how to be accountable. Success of the process is dependent upon the ability to clarify and teach this to the participants. It is also critical that they be held responsible by professionals to ensure quality participation that is supportive of the process. Those imposing external controls must be aware of the developmental status and capacity of the youth.

Accountability of the offender is also critical. Often offenders are operating under distorted thinking. This distorted thinking may impact their ability to be responsible. It therefore necessitates the need for external motivation and control to aid them in eliminating thinking errors and in accepting responsibility for their behavior and the harm they caused. This is best provided through a systemic approach utilizing the legal/supervisory system, treatment professionals, and caregivers.

Therapists engaged in treatment of youthful sexual offenders must at all times and in all treatment interventions be accountable and sensitive to the safety, desires, and needs of the victim, family, and community. Holding offenders legally responsible for their choices is not incongruent with the belief that they can change through the treatment process. It is also not incongruent with the need to protect previous and potential victims and the community from further abuse. Youthful sexual offenders can and will change if provided the opportunity for treatment. This can occur safely within communities.

Intervention Must be Safe for all Involved

Safety of all participants and of the community is the overriding principle in all interventions. Prior to the commencement of any phase, each participant must clearly verbalize that he/she feels safe. Also, at no time should any step or communication supersede the individual participant's right to safety.

Professionals must also prioritize and commit to the protection of the community throughout all treatment services. At no time should any phase or task place the community at risk.

A safety plan must be negotiated and agreed upon by all professionals and participants. This plan governs all communication, contact, visitation, and interaction between the offender and victim. A safety plan "provides the guidelines and safety measures that will decrease the risk of any recurrence of abuse" (Thomas, 2002, p. 3). This plan allows the victim to indicate what he/she needs in order to feel safe. It demands that caregivers develop rules to be implemented in their interaction and visitation with the offender. It allows professionals to instill rules and guidelines for victim and community protection.

Professionals involved must assess the caregiver's, parents', or family's ability to protect and support the victim. A clinical goal must be to strengthen the caregiver(s) ability to protect the victim and/or learn to effectively supervise the offender. The clinician should remain tuned in to any subtle intimidation or pressure placed on the victim by the offender or other family members, whether intentional or unintentional. This must be guarded against and stopped if it occurs.

In instances where the wishes of individuals conflict with the agreed-upon goals, services should be stopped. Also, where the wishes of family members or parents place individual participants or the community at risk, services should be stopped until these issues can be addressed or ameliorated.

Intervention Must be Beneficial

All participants should benefit from their participation. All interventions should be designed to promote the best interests and well-being of each participant. Services should be supportive rather than confrontational in nature. Resolution/reunification services should occur only when determined to be in the best interest of participants.

Treatment professionals working with sexual-abuse issues should believe that the restoring and reuniting of families is a priority; that the growth and development of children is best promoted when they live in a safe, functional, supportive family environment, preferably with their parents; and finally, that all participants should leave treatment empowered, healed, more capable of dealing with the impact of the sexual abuse, and capable of living healthy successful lives.

Intervention Must be Sensitive and Specialized for the Intended Population

Successful treatment services must be sensitive to and based upon the population for which they are intended. In this case they must seek to create interventions and services based upon a comprehensive understanding of the uniqueness of youth, of intrafamilial and sibling abuse, and on seeking to understand and integrate these concepts into its practices. The following section addresses issues that are critical in providing resolution/reunification services.

In resolving the trauma of youth-specific sexual abuse it is important to understand that both the offender and victim are youths (either child or adolescent) and as a result, all services must be sensitive to the uniqueness of what it means to be a youth.

The following section examines this in more detail. These concepts are presented in generalities designed to address a normative population. However, it must be remembered that in any group there are exceptions to which the normal standards do not apply.

The Nature of Youth

Childhood and adolescence are two distinct but connected developmental periods. They are a time of critical learning and development, characterized by profound and pervasive change. Children and youth are at a time in their lives when they can completely change every aspect of their persona in a short period of time. They hold a very different role and place within their family, peer group, society, and community. Children and youth are viewed as being in transition. They are learning and preparing to become adults. The expectations, rules, and obligations placed upon them are different. They exist and live in a very different world from adults. In this world, they are viewed as more open to receiving education and acquiring new skills. Their perspective is one of receiving, incorporating, and transferring new information into

their lives. Children and youth are motivated, stimulated, pleased, find joy in, and are influenced in very different ways than adults. They are characterized by experimentation. They experiment with new behaviors, attitudes, experiences, skills, needs, relationships, sexual feelings, and goals. It is a time when everything is in flux. This is characterized by inconsistency, poor regulation, and abrupt changes. This fluidity is also indicated by the presence of few fixed ideas and beliefs. Interests, hobbies, and pursuits are still developing and being defined. It is a time when outlandish, inappropriate, silly, and possibly hostile ideas, attitudes, emotions, and behaviors can be the norm.

Developmental Issues

Youth are in the process of achieving emotional, social, sexual, and spiritual competency. They are discovering and creating healthy cognitive structures. The personality is still forming and being defined.

Cognition

Youth are in the process of defining and refining cognitive structures, and as a result cognitive structures may still be fluctuating. This means that value systems and moral codes are evolving, making youth more susceptible to the values and moral codes of others. It also means there can be significant variation and fluidity in perspectives, beliefs, values, and morals. Attitudes and ideas are still forming which can be characterized by inconsistency and swings in both. Capabilities are still growing as youth learn and refine cognitive structure. Thinking skills are still in developmental stages, including gaining the ability to think in abstract terms and developing the capacity for insight and judgment. Attention skills are as well in developmental stages as they struggle with distractibility.

Youth are also in the stage of developing planning, coping, problem solving, goal- and need-attainment strategies which leaves them susceptible to environmental influences. It also means that they will experiment with varied skills and strategies in the course of developing and solidifying their skills. Finally, youth are developing the capacity for metacognition, which is the ability to analyze and have insight into the way they think.

Sexuality

Sexuality is still developing and as a result is in flux. Youth are seeking sexual knowledge and education while being bombarded by outside influences, sexual innuendos and messages. They are establishing sexual values, creating their sexual identity, learning to control and express their sexuality, and developing their arousal/desire profile.

Emotional

Development of emotional competency is a primary task of youth. Emotional competency requires the youth to understand, mature, regulate and learn to express their emotions in a healthy pro-social way. Emotional competency also requires the ability to emotionally relate to others, learning to recognize others' emotional cues and perspectives, understand one's impact on another's emotional state, and create the ability to empathetically respond. And finally, youth must develop the ability to emotionally connect with others. Because youth are still developing the ability to understand, regulate, and express emotions, they are more sensitive to negative feelings and depressed moods, experience more frequent mood swings, and

often feel an inability to control their emotions. As a result they are subject to more intense emotional responses and emotional variability.

Social

Each youth needs to become a social being and develop social competency. Social competency is the ability to achieve social developmental tasks, establish social relatedness, intimacy, and social skills. Social competency is also the ability to establish autonomy through creation of one's own identity, learning to enjoy relationships, recognizing the rules and expectations for relationships, and developing the skill to socially relate to others. And finally, social competency is learning to establish relationships, creating intimacy within relationships, and establishing healthy social skills allowing youth to demonstrate social mastery and confidence in social settings and relationships. In fact, youth are developing rather than acting as fully-developed social beings.

Neurology

The neurological system is still developing. As a result, skills, functions, and processes controlled by certain regions of the brain are still in developmental stages. Of specific concern are those functions controlled by the prefrontal cortex (which is still developing into late adolescence and early adulthood). The prefrontal cortex specifically controls executive functioning which is critical to rational and analytical thinking, emotional and behavioral regulation, decision making, and problem solving. Neurological development in youth causes performance of executive functions that have not yet matured. Lack of executive function leaves some youth with instability and inconsistency in their regulation of emotions and behaviors. There may also be more susceptibility to neurological rewards, urging participation in risk taking and exploratory behaviors to receive the desired reward.

Human Needs

Each human has needs that determine health, success and happiness in life. Adolescence is the time to develop the foundational skills and strategies to meet those needs. It is also the time to define commodities that bring happiness, success, and health. Youth are in the process of understanding, defining, and developing strategies to obtain their needs.

Resiliency and Protective Factors

Resiliency is defined by external and internal qualities and factors that allow youth to "bounce back" from contextual or experiential issues, traumas, or problems in a healthy or positive way. Protective factors insulate one from trauma. Youth are still in the process of defining internal qualities that provide resiliency from negative or unhealthy contextual issues or traumatic watershed experiences. Because these are still developing, youth are more dependent on external protective factors.

Experiential Issues

Humans are a product of life experiences. During childhood and adolescence, youth have significant watershed experiences that shape and define who they become. These experiences are internalized through cognitive and emotional structures and affect the perspectives one develops of self, others, the world, and one's moral code. Experience can be distorted and internalized in a harmful or unhealthy way when cognitive and emotional structures are still forming. This can

lead to distorted views, values, and morals. Traumatic watershed experiences have more impact on youth because of their developing nature. It also speaks to the youth's abilities to deal with traumatic experiences. The skills that allow successful framing and resolution are in flux and contextually dependent.

Given that abuse often occurs within the family or social environment of the youth, the influence of this environment is important in achieving successful resolution of the abuse. Environmental influence must be understood and accounted for in the development of a successful model.

Environment

Youth are embedded within a social environment, and are more dependent, influenced, and susceptible to environmental issues which include nature/quality of the environment as well as relationships contained within the environment. Youth are embedded within a family, school, peer group, and community, and are dependent upon these to aid them in their development and needs attainment. It can be said that youth are relationship dependent; needing the relationships around them to protect, guide, provide, and nurture their existence and development. The environment, specifically caregivers and families, plays a critical role in their life. As a result, youth are highly influenced and shaped by their environments. Also, due to the nature of adolescence, youth are in need of external structure and supervision to ensure success. They experience and expect a greater degree of external control.

Professionals must also be sensitive to the unique differences in intrafamilial and sibling abuse. The following section explores those differences.

Differences in Sibling Incest and Intrafamilial Abuse

Successful resolution and reunification must account for the unique difference that sibling incest and intrafamilial abuse creates. B. Mathews Hill (1999) wrote that, ". . . in recent years child abuse professionals have gained an increased awareness of the seriousness and emotional turmoil associated with sibling incest. . . " (p. 2). Often treatment services fail to take into account the differences inherent in sibling incest or intrafamilial cases. It is clear that intrafamilial relationships complicate sexual abuse dynamics, which in turn complicates resolution and reunification. The differences in intrafamilial sexual abuse appear to lie in several categories:

Quality of the Environment

The nature and quality of the environment has an impact upon how the abuse develops, occurs, and is dealt with. In intrafamilial abuse, both the youthful offender and victim share the same environment.

The environment is responsible for the nature and quality of relationships, as well as the nature and quality of functions provided by that environment. (See Appendix 1 for a list of functions the environment should provide for youth.)

Youth are dependent upon the environment. The nature of dependence, allows the environment to exert significant power and influence over developing youth.

The main component of any youth's environment is the family unit. The family unit has the primary responsibility to provide the relationships, functions, and qualities required for

healthy development. Therefore, the nature and quality of family impacts the abuse dynamics. It either aids in healing or complicates service delivery, or both. If the quality and type of relationships available are attuned, attached, supportive, and caring, they contribute to healing and resolution. However, if not, those relationships can sometimes undermine it. The values, coping skills, and need-attainment strategies taught and modeled in families can impact the youth in either a positive or negative way. Obviously, if healthy values and strategies are modeled, the youth is more likely to develop a healthy cognitive structure with healthy coping and problem-solving skills. Conversely, the opposite can occur if the family teaches or models dysfunctional or unhealthy values and strategies.

The level and quality of supervision available in the family can also impact resolution of abuse in either a positive or negative way. If the family is capable of supervising and enforcing needed changes in the environment, resolution is likely to be successful. However, if the family is not capable, success is less likely.

The quality and nature of skills taught in the home can also impact success. If healthy interpersonal, intrapersonal, and achievement skills are taught and modeled, resolution is more likely to be successful. If those skills are not taught and modeled in a healthy manner, the opposite is likely.

Additionally, if the environment provides a healthy stage and milieu for development, youth are likely to achieve developmental competencies. If there is not a healthy stage, those youth may experience developmental failure. It is also within this environmental milieu that youth learn resiliency or conversely develop deficits or vulnerabilities.

In sibling-incest cases, both the perpetrators and victims are embedded in and experience the same environment. Therefore, the impact of the quality and nature of the environment is amplified. Therefore, because the environment has a significant impact upon the success of treatment services, any negative, unhealthy, or harmful qualities or relationships in the environment, complicates the success of services. These environmental issues must be ameliorated, as much as possible, as part of treatment and prior to reunification.

Nature of Families

Each family is uniquely different. However, in intrafamilial cases, several critical similarities exist that impact the nature of the abuse dynamics and in turn complicate treatment services. Most families seek to remain intact. The level of functionality or dysfunctionality in families is perceived as normal, and does not necessarily create a desire to disband. If families are divided by abuse, most will seek to reunify. It is likely that most family members will have a strong desire to maintain family relationships. This clinical assumption indicates that in intrafamilial cases, many or most victims will seek a relationship with the individual that hurt them. It also indicates that members of the family may seek to restore or rebuild bonds of love and trust, or continue to express strong feelings of affection. This includes the victim desiring to rebuild bonds of love and trust towards the offender.

Each family establishes a level of functioning, and most members are comfortable with it. Abuse alone may not create enough discomfort to force changes in the family structure. Also, since each member has a unique individual function and role within the family unit, individual functioning may impact the overall family functioning. In order to establish a healthy family unit, therefore, it is important that each individual learn to function in a healthy way.

Each family establishes unique dynamics, including coping mechanisms for stress, pressure, and problems. When sexual abuse occurs in the family unit, it is critical to understand

the unique way the family and each individual deals with it. Family roles, lines of authority, and control need to be clearly understood and, if problematic, ameliorated prior to reunification.

It must also be understood that the removal of a family member due to the abuse, will allow the family to reconstitute itself. Prolonged removals will allow the family to re-solidify differently, impacting relationships, level of functioning, comfort zones, and day-to-day functioning. If not understood and accounted for re-solidifying can impact successful reunification. Professionals need to take into account that the family must reconfigure at time of reunification.

Differences in Relationships

There exist inherent differences in relationships between offenders and victims within sibling incest or intrafamilial abuse cases. Successful treatment services require professionals to understand and account for these differences. Yantzi (1998) reminds us it is within the relationship that the trauma or damage of the abuse is rooted (p.72). Yantzi also states, ". . . it is critically important to include this [the nature of the relationship] in the healing process. Sexual abuse survivors and those who offend sexually are human beings who become connected to each other, and fragmented within themselves, by unspeakable behavior of a sexual nature." (p. Preface)

Sibling relationships can be characterized by factors and dynamics that make resolution of abuse different and more complex. Among these is the inherent complexity of the relationship. Sibling relationships are often characterized by existing roles defined by the familial environment and the siblings themselves. These relationships are characterized by defined or inherent authority and accepted power differential (i.e. older brother), differences in expectation and accountability (i.e. male or female, older or younger), individualized language and communication style (i.e. how siblings talk to each other), similarity of environment and experience, and similarity in values, moral codes, familial secrets, thinking errors, confidences, loyalties, coping and problem solving skills. These relationships have often been established and practiced from birth and lead to dynamics that impact the abuse and potential resolution of the abuse.

Youth learn through family interaction and personal experience how to deal with misbehavior which impacts resolution and reunification. Often when misbehavior happens in a family setting, youth are taught to say they are sorry (without much or any remorse). This apology is meant to reestablish balance and homeostasis in the home. The one harmed is taught to accept the apology (without question or resolution) and move on. So often, in intrafamilial abuse, members of the family seek this type of resolution. However, this type of resolution fails to explore etiology, and misattribution of blame and responsibility. It also fails to correct the abuse dynamics, and/or heal the pain. This dynamic must be understood and accounted for.

Parental Trauma and Confusion

Parents who discover that one child has sexually victimized another of their children face an incredible level of trauma and confusion. The intervening legal and intervention process may add to this trauma. In successful treatment services, it is critical that professionals understand the level of parental trauma and confusion and seek to address it. Professionals must remember that parents are often placed in a difficult position where they feel they have to "choose" between the victim and the offender (Center for Sexual Offender Management, 2005, p. 11). This may create confusion when offering parental support and loyalty to either the victim, the offender, or both.

Ryan and Lane (1997) write, "When the sexual abuse is committed by one child against another in the family, the family quite naturally will have feelings of divided loyalty. Parents and siblings usually love both children and will be confused about how to show that caring in this circumstance. There is a great deal of pressure to keep the family intact by dealing with the problem within the family" (p. 384).

It is important to understand that successful resolution and reunification is only possible when parents and caregivers have been assisted in working through their own trauma associated with the abuse. Keep in mind also that the abuse may trigger unresolved traumas in parents that also must be healed.

Reunification Pressure

The desire to remain intact or reunify after the abuse, coupled with the desire for normality, the wish to maintain relationships, and the dynamics of sibling incest relationships can place a covert or overt pressure on family member(s) to resolve the abuse. This pressure may be spoken or unspoken, and can often specifically target the victim. This desire within the family may increase victim confusion, trauma, and desire to forget about or to avoid dealing with the abuse trauma. Victims or other family members may feel that they do not have a say in, or cannot stop treatment services from occurring, even though they may not desire it or feel safe. This unspoken desire to reunify may drive trauma underground and may also serve to solidify abuse dynamics and misperceptions. Hill (1999) reminds us that even "benign" familial or parental pressure is felt and must be dealt with by the child (p. 5). Successful resolution/reunification must understand the pressure family systems place on victims and ensure that all receive adequate treatment and support to heal the abuse trauma.

The resolution and reunification model presented in this book represents a step-by-step guide for therapist offering this treatment service. It contains six phases that each have identified tasks.

Chapter Two

Phase 1: Getting Started

The first phase of resolution/reunification is a preparatory stage and is intended to begin once the abuse is detected and intervention is determined to be necessary.

This phase is clinically initiated, which indicates a therapist begins the process. Any professional can initiate the process, however, it is best initiated by the youthful sexual offender's therapist. In almost every case the youthful sexual offender will be referred to treatment and, as a result, in almost every circumstance there will be a therapist assigned to provide treatment to the offender.

Resolution and reunification services are best when all professionals involved in the case collaborate together including individuals from the legal, supervisory, or treatment system. However, based on time, systemic, and financial constraints this may not always be a possibility. The next best option would then be collaboration between the victim's and offender's therapist. The model, however, can still be used by a single therapist who plays the primary or lead treatment role with either the victim or offender, but who can also clinically advocate for other participants. This is not the ideal but still can be effective.

If possible, communication between all professionals involved in the case should be organized. Professionals should agree to cooperate. The primary/lead therapist should contact the other therapist(s) involved (i.e. victim, family, or offender therapist) and other key stakeholder(s) (probation officer, caseworker etc.). These professionals should be advised and offered a chance to participate as well. If there is no other therapist or key stakeholder involved, the primary/lead therapist should proceed with the steps as outlined.

It is through professional cooperation and collaboration that participants are supervised, held accountable, and safe. This systemic approach ensures professionals are aware of the individual participants' needs and desires, and are sensitive to any changes in risk, need, and circumstances, thereby ensuring that services are sensitive to individual needs.

The primary/lead therapist should act as the coordinator with all involved professionals. All involved professionals work on several primary and preparatory steps.

Step 1: Preparation:

1. *Identification of desired participants*
   All who are impacted by the abuse should be given a chance to participate in resolution/reunification services. This could include a variety of family or community members. Participants will be as varied and each case itself. However, consideration must be given to any individual that is believed to benefit from participation. At a minimum, resolution/reunification services should involve the youthful offender and his or her family, and the victim(s) and his or her family(ies).
2. *Obtain informed consent*
   Taking part in resolution/reunification interventions requires the informed consent of all participants. This indicates that the participant is intellectually, emotionally, and developmentally capable of making an informed decision about his or her participation, and has adequate knowledge to assess how participation could benefit him or her. He or she also understands the risks, safety concerns, and ramifications of participation, as well

as a clear understand that participating can impact well-being in a positive way. The inherent difficulty is that commonly victims are children, and the offender is an adolescent. The nature of youth and developmental status indicates participants may not be capable of making an informed decision about resolution/reunification services. This does not prohibit him or her from learning and understanding the nature of participation. Child and adolescent participants should be provided with a clinician or clinical advocate, have access to a legal guardian/caregiver or adult support to help him or her determine the appropriateness of participation. The individuals helping the participant to make the decision must be clearly aware of the benefits, risks, and ramification of participation. This enables him or her to assist the child or youth in making a sound decision.

3. *Obtain caregiver consent*
   Caregivers play a pivotal role in the lives of children. It is critical that prior to commencement of any resolution/reunification services the caregiver is fully informed and supportive of services. This ensures participant support and safety, while also providing a means of supervising the interaction and evaluating the impact of the services.
4. *Identify best interest of participants*
   Identification should be made that resolution/reunification services are in the best interest of participants, that the individual(s) will receive clinical benefit, that services can be administered safely, and that there are no contraindications that would indicate services should either not occur or be postponed.
5. *Determine clinical necessity*
   All services must be anchored in the clinical needs of each participant. This ensures the clinical necessity of all phases, interactions, and tasks.
6. *Create a healthy forum*
   This milieu is highlighted by all participants feeling, heard, part of, and valued. They also must feel respected and capable of stating an opinion.
7. *Gather and disseminate information*
   This initial information allows professionals to better identify the details of the sexual offense, who perpetrated it, and who was harmed. It also allows for the discussion of discrepancies in the story and can provide feedback for the legal disposition of the offender as well as the supervision and treatment needed. It allows clinicians the needed information to hold offenders accountable, and to help victims and families heal. Professionals should work to gather all police and child protective service reports, court documents, victim/family/offender statements, and other pertinent documents. This information should then be disseminated and discussed by all professionals involved. This will require releases or court orders. Also, when sharing victim treatment or trauma issues the victim's rights should be carefully guarded. Confidential information should be shared only when clinically necessary, and should be received and treated in a professional and confidential manner.
8. *Engage and empower participants*
   Professionals work to engage each participant into resolution/reunification services. Participants are informed of the potential benefits of their participation. They are helped to express a desire and commitment to participate in the process. It should also be remembered that often the victim(s) are children. Therefore, professionals need to understand the victim's age and ***never contact child victims directly.*** Contact should first

be made with the child's caregiver or guardian. It is also critical that the families of victims and offenders be engaged and committed to the resolution/reunification interventions. Remember, both the victim and offender are typically children and need the support and guidance of their families. Engaging families in services increases the likelihood of success. It is critical that professionals work to ensure all participants feel empowered. Empowerment is achieved when participants feel heard by the investigative, legal, supervisory, and treatment systems. When they believe that their desires, opinions, rights, and decisions are valued, they feel that they have a voice in the process and believe that their participation is their choice. Participants must believe they can speak safely, and that their desires will be respected and adhered to by professionals and other participants (especially the offender). Finally, each participant must believe they are receiving the attention they deserve, that they have choices and options in the process, and that they have a sense of control over the process.

9. *Resolve difficult questions/decisions*
   The resolution/reunification process is fraught with many difficult decisions (see table 2-1 for a list of possible difficult decisions). Professional(s) must address and find healthy solutions to difficult questions. The answers to these questions affect the course of services. These questions will be addressed in greater depth in chapter 9.

Insert table 2-1

10. *Individualize services*
    Resolution/reunification should be tailored to the individual needs, desires, and best interests of each participant. All phases, goals, and tasks should be flexible enough to adapt to and be driven by uniqueness of the case and the individuals involved. The process must be based on the participant's individual willingness to participate, his or her desires, and clinical needs.
11. *Establish parallel treatment process*
    In Phase 1 it is important that professionals explain to each participant the parallel treatment process and obtain his or her approval and commitment to participate in a clinically-facilitated communication. Professionals must then create a safe milieu and method for this communication to begin.
12. *Create support network*
    It is critical that participants (including the offender) are helped to establish a support network prior to their participation. This is especially true if the participant is a child. In fact, the success of the process increases when participants feel supported. This support allows participants to feel empowered, cared about, protected, and supported during the process. It helps them feel that they are not alone and creates an opportunity for them to express and process their experience. This is best accomplished for children when their caregiver provides the primary support; however, it can be enhanced by others when caregivers are unwilling or incapable. The professionals need to help participants identify and establish a support network. Child participants (both victim(s) and offender), should have a supportive caregiver. If unavailable, significant family members (grandparents, adult siblings, aunts, uncles etc.) can play this role. If significant family member support is not available, family friends, religious leaders, teachers, mentors, foster or proctor parents, coaches etc. can provide support. Each participant should have an adult

supporting them. Participants should also have a clinical advocate. Typically this will be the youth's individual therapist. However, if the youth is not in therapy, a therapist who has knowledge of the case, is experienced in sexual abuse cases and the resolution/reunification process should be assigned to advocate for the clinical needs and rights of the child. This ensures that each participant has someone who is advocating for his or her rights and needs, and is the identified individual in whom he or she can confide. Additionally, child victims may also want the support of a close friend. Youthful participants should be allowed to identify friends who could support them. Caregivers and professionals should then determine the appropriateness of adding the close friend to the support network. Friends can attend resolution/reunification sessions with the youth, if appropriate, or they may simply support the youth through their friendship. Children and youth may also choose a participant from their clinical group. Group inclusion is an important factor in helping victims feel that they are not alone in their experience, and helps them reframe their experience and misattributions. Adult participants (caregivers, family members, etc.) should also be encouraged to establish a support network. This can include parents, siblings, other family members, and friends, as well as individuals who have experienced similar issues of abuse in their family. Parents can be encouraged to attend support and education groups, or can be introduced by professionals, if appropriate, to other adults who have experienced similar circumstances. Adult participants should also have an identified clinical advocate. This could be their own therapist, or the child participant's therapist, who will advocate for their clinical issues and needs.

With completion of the above steps participants are now ready to begin the resolution/reunification process.

Step 2: Clinical Assessment of Participants

It is strongly recommended that each participant be clinically assessed. This may not always be possible due to fiscal, systemic, and time constraints. The assessment is designed to evaluate impact of the offense, individual functioning, co-morbidity, risk and vulnerability, and individual treatment needs. It is recommended that the victim (includes all harmed by the offense), the offender, and the family (both the victims and the offenders) be assessed. At a minimum the offender and victim(s) should receive an assessment.

Victim Assessment

The assessment should include a comprehensive mental health assessment (the typical procedure in assessing victims). This assessment may also include a psychological and psychiatric assessment as deemed necessary. The focus of the assessment should define the individualized impact of the abuse trauma, vulnerability, and treatment needs.

Family Assessment

The assessment should also include a comprehensive assessment of the victim's and offender's family. This should be included as an adjunct to either the victim's or offender's assessment. It is important to remember in sibling incest cases the victim and offender share the family unit. Problems in families can usually be divided into four areas:

1. Unhealthy Familial Dynamics and/or issues

2. Problems in caregiver functioning and abilities
3. Caregiver's inability to provide necessary functions
4. Nature of the Relationship.

Therefore the family assessment has four parts:

The primary assessment of unhealthy or problematic dynamics or issues should focus on:

- Abuse/Neglect
- Domestic Violence
- Substance Abuse (in the youth)
- Mental Health Issues (In the youth)
- Unhealthy Value or Moral Structure
- Unhealthy Coping, Need attainment, or Problem solving Skills
- Unhealthy Communication Patterns
- Negative or unhealthy attitudes, thinking errors, or behaviors
- Negative or unhealthy parenting style, attitudes, and/or Discipline
- Unhealthy definition of roles

The secondary assessment should determine problems in the caregiver's functioning in these areas:

- Unhealthy cognitive structures, value systems, moral codes, and paradigms
- Unhealthy emotion management or expression (anger, depression, anxiety)
- Unhealthy attachment, attunement, intimacy, affection, nurturing, or relationship style
- Social competency issues
- Mental health issues
- Substance abuse
- Criminal behaviors
- Criminal or antisocial thinking
- Failure to model healthy standards, principles, values, expectations, morals, and a cognitive blueprint
- Own unresolved trauma or grief issues
- Negative self-perception or worth
- Employment/financial problems
- Marital/Relationship issues

The tertiary assessment includes the caregiver's ability to provide the necessary functions including:

- Providing a healthy stage on which the child develops and grows
- Supporting, guiding, and nurturing the youth's development and growth
- Preparing the youth to be a successful adult
- Providing a healthy milieu to practice developmental competencies
- Instructing and guiding the youth's obtainment of developmental competencies
- Allowing the youth practice developmental competencies and achievement skills
- Performing and providing healthy familial roles and functions by providing a structured, safe, quality environment

- Providing supervision, feedback, and consequences
- Creating a healthy learning environment
- Aiding the youth in recognizing their susceptibilities and vulnerabilities
- Instilling resiliency
- Providing healthy role models
- Providing a healthy milieu for experience
- Providing a milieu to meet human needs

The quaternary assessment addresses problems within relationships and desires to restore the family relationships including:

- An assessment of the nature of the relationship between family members
- The desire of family members to restore relationships
- The state of the current relationships
- Identification of dynamics or issues that block the creation or restoration of the relationship
- Level of attunement and empathy
- Current communication patterns
- Current level of trust
- Current definitions of roles
- Level of love bond
- Impact of the abuse on the relationship

Keep in mind there are no perfect families. The goal of the assessment is to identify areas of weakness and then through resolution/reunification services increase functionality where possible. It is not necessary for families to achieve all outlined criteria; this is too much to ask of any family. However, the creation of an attitude of improvement or progression is desired. Services should help families to inspire to be better, and create an understanding of where they can improve, and how.

If possible an assessment of each caregiver is advised. This assessment should evaluate their ability to perform and provide familial functions roles in a healthy way, as well as their level of functioning and individual treatment needs. (Caregiver roles and functions are defined in Addendum 1.)

Offender Assessment

Offenders should also receive a risk assessment to determine their risk potential, etiology of offending, and treatment needs. A psychological and psychiatric assessment should also be performed as needed.

Ongoing Process

Professional(s) must also recognize that the assessment of participants must be an ongoing process. As the Center for Sexual Offender Management (2005) stated, “responsible reunification practices require the ongoing assessment of risk and needs” (p. 5). A procedure to assess participants in an ongoing basis should be established. It is recommended that an assessment occur at the completion of each phase and prior to advancing to the next phase. This

should evaluate each individual and the need to continue, modify, postpone, or discontinue the process.

Step 3: Referral of Participants to Specialized Individual Treatment

Once the assessment is completed it is recommended that each participant be referred to individual therapy. Resolution/reunification services are best accomplished when all participants are involved in individual therapy. However, many abuse intervention systems are not set up to ensure that primary and secondary victims and families receive treatment. Victim treatment has not been a priority of the system and has often been overlooked, although it is critical to successful resolution/reunification. Additionally, some parents may feel that the victim does not require individual therapy because the child may be asymptomatic, or they mistakenly fear that treatment will focus the child on the abuse and complicate healing. Whatever the reasons, parents must understand that victim treatment is an important part of the resolution/reunification process. They need to accept and support this, and provide the opportunity for their child to participate. Without individual treatment for victims, conducting ongoing assessment, achieving individual treatment goals, and successfully accomplishing resolution/reunification tasks are much more difficult.

Individual participation in treatment ensures that each person has a clinical advocate through which to process his or her experience of the abuse and the resolution/reunification process. It also allows for the identification and treatment of individual needs. It is through individual treatment that participants define their needs, desires, and expectations, and prepare for the resolution/reunification process. Finally, the individual clinician serves as an objective clinical voice aiding the team in monitoring the well-being of the participant and aiding in determining the clinical necessity of interventions, readiness, and services that impact the participant.

If a participant cannot attend individual treatment it does not mean the process cannot work. It is recommended that offenders be in treatment, and strongly recommended that victims be in treatment. If it is not possible for the parents, victim, or other participant to be in treatment, the offender's therapist must clinically advocate for them. This means that in making decisions and conducting, the victims', parents', and/or other participants' clinical needs and desires are known and incorporated into the process.

It is now time to begin the resolution/reunification services. These services begin with the clarification phase.

Chapter Three

Phase 2: Clarification of Abuse Issues and Dynamics

Phase 2 is clarification. Sexual abuse by its nature causes a multiplicity of questions and unresolved issues and dynamics. The Center for Sex Offender Management (2005) writes that clarification is "designed to provide a safe forum for family members to openly discuss the sex offenses that occurred. Typically, this is the first opportunity for the offender, victim, and other family members to safely and directly address the abusive behavior as a family." (p. 9).

Clarification is a procedure that promotes clinically-facilitated communication between the offender, victim, family, and others impacted. The intent of this communication is to clarify the abuse experience, the resulting issues, and the dynamics. Specifically, this communication is intended to clarify the offender's legal disposition, placement, and treatment. It identifies what occurred in the abuse, who is responsible for it, and why it was wrong. It also serves to relieve victim misattributions, to identify and define offender thinking errors and harm caused, as it clarifies abuse questions, and dynamics, and familial issues. It also defines the issues that need to be resolved in the resolution phase. Clarification is a prerequisite to resolution, reconciliation, reintegration, and reunification.

The clarification phase begins when participants and professionals mutually agree it is appropriate, and the participants are ready and have met the defined criteria for preparation. (This criterion will be outlined in Chapter 8.) The clarification phase ideally takes place over a several clinically-facilitated communications. As Mussack and Stickrod (2002) stated, "Clarification is not a one time, static event which has a clear end point. It is a dynamic process which is continually reviewed throughout therapy." (p. 1)

It is recommended that the offender's therapist initiate and facilitate the clarification phase, because the offender plays the critical role. Offenders must acknowledge that they committed the offense and own responsibility for it while helping the victim disown responsibility. The offender must accept that the abuse was wrong and caused harm, and must respond to any question asked by those impacted.

Although the offender's therapist initiates and facilities clarification communication, it is recommended that the victim's therapist be involved. However, if the victim does not have a therapist, the offender's therapist should then evaluate the impact the communication may have upon the victim. The therapist should deem the communication is clinically necessary (for the victim) and is based on clear goals and objectives that have been agreed upon by professionals and participants.

Clarification is designed to establish a parallel treatment process which opens the communication channels on specific clinical points. These points aid in the achievement of individual treatment goals, thereby helping participants heal. Communication/clarification occurs over specific points outlined in the tasks of the phase, and is a prepared presentation not a dialogue. Clarification is not the time for processing or discussion, it is simply intended to identify and clarify the experience, issues, and dynamics. The resolution phase is designed for a more in-depth discussion. It is recommended that the communication not stray from the intended purpose or stated goal. Often participants have not progressed in individual treatment far enough to allow more detailed discussion. Therefore, clarification is a presentation of prepared material

designed to accomplish or clarify specific clinical points, goals and objectives. (These goals are outlined in table 3-1.)

All communications must be clinically approved, directed, and supervised. Professional deliberation is required to select the goals, communication points, and method of communication. This means that the professional(s) must aid participants in identifying those areas needing to be clarified. Professionals must keep in mind that victims are often children and do not have a clear perspective on the event or how to process it, especially since the experience of the abuse lies outside the limits of normal coping skills. Professionals need to assist participants by identifying areas in which a clinically-facilitated communication could help. All participants should benefit from participation in the clarification process. (Possible benefits of clarification are outlined in table 3-2.)

Insert Table 3-1 Goals of Clarification

Insert Table 3-2 Benefits of Clarification

Clarification Steps

The clarification process has five steps. These are progressive in nature. Step 1 must be accomplished before Step 2, etc. Steps 1, 2, 4, and 5 are reoccurring and need to take place at the beginning and/or end of each phase. A similar process needs to occur in each proceeding phase.

Step 1: Determination of Readiness

The key to success is ensuring that participants are carefully and clinically prepared prior to their participation. Careful preparation of the participants ensures safety and success of the phase. Inadequate preparation increases risk of failure and potential for retraumatization and harm to the participant. “Given the complexities involved in intrafamilial child sexual abuse cases, professionals working with these families must take great care in ensuring that victims, families, and offenders are in fact ready for reunification to occur.” (Center for Sex Offender Management, 2005, p. 3)

Phases should not be initiated until participants are ready for participation. If a participant is not in readiness, he or she should be helped in ameliorating any issues or problems that prevent being prepared. The only exception to this is a statement made by the individual that he or she does not wish to participate. In this case, his or her desire should be honored. Determination of participant readiness has five parts: professional assessment of participant readiness, participant’s assessment of readiness, caregiver’s permission for participation, achievement of prerequisite treatment goals, and assessment of family functioning.

Professional Assessment of Participant Readiness

A professional evaluation of each participant’s readiness for the given phase must occur prior to commencement of the phase. This evaluation revisits several items from the initial assessment and should affirmatively answer the question; *Is participation in the phase in the best interest and clinically necessary for the individual, and is the individual’s support network still sufficient?* The professional should then make a determination of the participant’s ability to take part in the procedures, as well as a determination of the potential impact of the services upon him or her. The stability and emotional wellbeing of each participant should then be assessed. Each participant must be assessed as mentally and emotionally stable prior to participation.

Professionals should assess the participant's impression, interpretation, and perception of the goals and tasks of the phase. The professional should determine if the participant's perception is accurate and positive and if not should determine what needs to be reframed or changed. An assessment of how the tasks and communication may impact (or has impacted), the participant needs to occur. The desire of the participant to continue their involvement in the resolution/reunification process should also be determined at this point. An assessment of needed modification that will improve either safety or the process should be made. The professional should then outline the best course of action for the phase by identifying the tasks to be performed. And finally, the professional should inform the participants of the potential risks and benefits of the phase.

Participant's Assessment of Readiness

The individual's own assessment of readiness for participation is important. Each participant should be able to verbalize that participation is voluntary, can make the decision to participate of his/her own free will and volition, has clearly defined resolution/reunification desires, needs, and goals, understands the purpose of the given phase with its goals, steps, and risks of harm. Participant must also feel empowered, feel ready and willing to participate, can identify safety needs and resolution/reunification desires, believes those desires will be respected and by professionals and other participants, feels adequate attention is being given from professionals and other participants, has a voice in the decision making process, feels control over the progression of the resolution/reunification services, has clearly verbalized a commitment and desire to heal and reunify, and verbalizes he/she understands the benefits of participation. Participant must also be made aware that they can decline participation, and understands that there are different closure and participation options,

If a participant declines participation he/she should not be forced to do so. However, the benefits of participation should be clarified. If the participant chooses not to participate he/she will be moved on to Phase 6. Lack of participation should be periodically reviewed to assess if desire to participate has altered.

Caregiver's Permission for Participation

As is often the case, many of the participants will be children, therefore, the participant's caregiver (or significant adult) should simultaneously be informed of the professional recommendation for the given phase. The caregiver(s) should make an independent decision regarding the child's participation. If recommendations differ, a meeting should occur to resolve the differences.

Achievement of Prerequisite Treatment Goals

It is recommended that whenever possible participants receive individual treatment or, at a minimum, has an assigned clinical advocate. Preparation occurs in individual treatment and readiness is determined by achievement of the prerequisite treatment goals. (Criteria for readiness for each phase is addressed in Chapter 8.)

Assessment of Family Functioning

Professionals should gauge what familial issues or barriers will complicate the administration of resolution/reunification services. This can occur by revisiting the initial family assessment and determining what issues or factors are still present and must be addressed prior to

the phase. Once identified, a plan needs to be developed to ameliorate or eliminate these issues prior to commencement. This does not mean the issue needs to be resolved, only that its impact upon the successful completion of the phases/tasks can be controlled.

Step 2: Assessment of Safety and Safety Planning

Prior to the commencement of any phase an assessment of safety issues and concerns must occur. It must be determined that the safety-needs, risks, and concerns can be adequately controlled in a safety plan prior to commencement.

Assessment of safety should include:

- An evaluation of the offender's risk/dangerousness as well as the potential he/she presents to cause further harm to the victim(s) or others in overt or covert ways
- The vulnerability of the victim, safety needs, impact of the abuse, resolution/reunification services, and communication with the offender
- Subtle or overt intimidation/pressure placed upon the victim to reunify
- Unhealthy resolution/reunification motivations possessed by any participant
- Mental health issues or unresolved trauma that negatively impact individual or familial functioning
- Thinking errors that deny, minimize, excuse, or rationalize any aspect of the abuse, and that prevent accurate and healthy clarification and resolution of the abuse, and impact reunification
- Unhealthy individual dynamics or behaviors such as substance abuse, criminality antisociality, domestic violence, anger issues, abuse, etc.
- Lack of motivation and commitment to change, lack of clinical achievement on required individual treatment goals
- Lack of commitment to the protection, general wellbeing, and healing of each participant
- Lack of commitment to resolution/reunification interventions
- Lack of commitment to follow the designed safety plan

Each participant is also given the opportunity to identify and express his/her safety needs and concerns. Participants should feel that they have a voice in the safety planning process, have been informed of potential risks of harm and have been aided in outlining fears as well as what is needed in order to participate safely.

Perhaps the most critical task is developing a plan to address safety concerns. Safety planning relies upon a professional assessment of risks and concerns. However, it must also be sensitive to the expressed safety concerns of participants. Intervention or communication should never supersede the individual participant's right to safety. Treatment or intervention should never place the community at risk.

Once all safety issues and concerns have been identified by participants and professionals, a safety plan should be created to address them. Developed and agreed upon by all professionals and each participant, the safety plan specifically outlines risk issues and needs.

At this point a contract is drawn up, agreed upon, committed to, and signed by all professionals and participants. The contract should address professional and participant concerns and should also outline:

- Rules for behaviors, interactions, communication, and honoring boundaries

- Rules for clarifying safety needs and alleviating unintentional contact
- Restrictions and boundaries for interaction
- Rules for potential negative interaction
- Supervision rules and expectations
- Consequences for violation of rules
- Commitment to maintain safety of participants
- Code of conduct and expectations for the offender
- Termination or postponement procedures based on risk and safety concerns
- Ability of participants to postpone or terminate the process if they feel unsafe
- Intervention of professionals in terminating the process based on sound clinical criteria.

All safety issues and concerns do not need to be completely eliminated, however, professionals need to believe the issue can be controlled during the phase. Ideally, however, prior to conclusion of services the issue should be eliminated.

Prior to moving forward, all participants must verbalize that safety concerns have been heard and will be addressed and can participate safely in the process. There must also be a willingness to accept the risks and participate in the development of a safety plan.

Termination of services does not necessarily mean that it will never occur again, it only means that it will be terminated until the safety and risk concerns can be addressed. The plan then, as stated before, requires all participants to verbalize that they feel safe and are committed to follow the plan.

Professionals must ensure that the physical environment in which clinically-facilitated face-to-face communication occurs is also safe. This is best served when it is a neutral setting or one that favors the victim. The victim must clearly verbalize feelings of safety and comfort with the chosen setting. If the setting must occur in the offender's venue (residential treatment program, etc.), it is important that the victim sees and experiences the setting prior to the session. This will allow some familiarity and comfort during the session. It is always recommended that the session take place in a clinical setting so that the circumstances can be controlled.

Step 3: Selection of Communication Points or Clarification Tasks

Each phase will identify potential tasks. These tasks are not mandatory, but do represent the options available to professionals and participants. It is through completion of the tasks that the phase is achieved. Tasks should not be viewed as a clinical checklist, rather professionals and participants should select the task that best fits their needs. It is in this way the process is individualized to its participants.

Tasks are also called communication points. This indicates that each task defines a point of clinically-facilitated communication between the offender and those harmed. The tasks define the content of the communication. In clarification, communication is a presentation of prepared materials, not a discussion. This does not mean that a communication cannot be responded to, or addressed; however, professionals must ensure that the communication does not exceed the level of preparedness of the participants. For this purpose it is recommended that all communication be static rather than dynamic in content and presentation.

After selection of the task, professionals must aid the participant in creating the desired message for each task, and then sharing that message. Professionals need to ensure that they initiate and facilitate this activity by monitoring and supervising the presentation

(communication). Professionals must ensure that all communication is clinically needed and delivered in a healthy and appropriate manner, and that it is focused and congruent with the selected task and goal.

Below are the potential communication points for the clarification phase. Professionals and participants must select the desired tasks and the methods of communication.

Communication comes in many forms. The selection of the method is indicative of the level of readiness of participants, the least intrusive method should be chosen when possible. (Table 3-3 outlines different methods of communication.)

Insert table 3-3 Possible Methods of Communication

Task: Provision of Information

This task is designed to allow participants to share critical information. It begins with those impacted by the abuse, receiving information regarding the offender's legal disposition, removal from the home (if removed), placement (if placed outside of the home), intensity of treatment, goals of treatment, and potential discharge dates.

Often victims and victim's families hear nothing about the offender after the initial investigative interviews if offender is not in the family, or has been removed from the home. This often leaves them unprepared for reunification or contact with the offender. Even if the offender is in the family, victims and family members are often not incorporated into the offender's treatment the way they need to be. In these cases, the discrete treatment systems do not interact the way they need to by providing in-home victims with critical information. As a result, this first task allows the offender to communicate what happened in court, location of placement or, if not placed, location of treatment and what he/she is doing in treatment, i.e., therapy goals, rates of success (that treatment is effective, etc.), the pathway to clinical success, and timeframes for completion or discharge. It needs to be communicated that timeframes are flexible in nature and depend upon many things. The offender may also periodically communicate regarding treatment progress. This could indicate what he/she is learning and/or struggling with. The victim, family, and anyone impacted should be given the opportunity to respond to the offender's communication. This communication may be in the form of asking questions, disagreeing with a statement, or offering support.

Those impacted and harmed, specifically the victim, if in treatment, may also communicate regarding their treatment goals, issues, struggles, and progress. This should be done with caution. If the offender has not progressed to a point where this information can be received and responded to in an appropriate healthy manner, it should not occur. No information should be provided to the offender that could be used to continue the abusive relationship or dynamics, or would support continuation of cognitive distortions (especially around responsibility). If it is determined inappropriate to share victim treatment information, the offender should still be educated regarding general treatment goals, issues, struggles, and treatment strategies for sexual abuse victims.

Information in this task is provided for educational purposes only. It is not yet time to discuss this information. This will occur as participants identify the issues and dynamics they desire to resolve in the next phase.

Task: Acknowledgment of Abuse Occurrence

It is critical to the treatment of victims that they receive reassurance from others that the abuse occurred and that the victims are believed. It is just as important for offenders to acknowledge that the abuse occurred. This is often a prerequisite allowing the offender to own responsibility for committing the offense.

This clarification assignment begins with the offender communicating that indeed the abuse did occur and acknowledging commission of the offense. The offender should be required to write a full description of the abuse events. Discretion should be used in determining how this statement is used. The point is to aid the offender in acknowledging the abuse and is not intended to inform all participants about the abuse details. Professionals need to make a good clinical decision about how the disclosure details are used. The victim should also be clinically aided in revealing the abuse events. This is approached differently than with the offender, where the offender is required to write the events, the victim should be clinically supported in verbalizing the events. It is the professional's responsibility to ensure the events are recorded.

Professionals should then take the disclosure of the offender and the victim and compare them, identifying any major discrepancies. Seeking clear and concise agreement on the events of the abuse may lead to frustration and disagreement as memory is perceptional. The intent for the offender is accountability for offending behaviors. The intent for the victim is to be heard, believed, and aided in healing the trauma. Individual disclosures are based in the participant's perception of the incident, therefore discrepancies are not uncommon. However, any major discrepancies in the story should be addressed with the offender to ensure that there is full disclosure.

It is also important that critical others acknowledge the abuse. This includes the offender's caregivers, and the victim's caregivers and family. This acknowledgement serves to confront and eliminate caregiver's thinking errors. It also helps to create support for change and healing of victim, offender, and family.

Task: Realigning and Clarifying Responsibility

The next task of clarification deals with realignment and clarification of responsibility for the offense. Often the responsibility dynamic is backwards where the victim and caregiver(s) feel they somehow caused the abuse, while the offender is fighting to not own the choice of offending. This task focuses on realigning this dynamic. It works to help the offender own accountability for the abuse by breaking through and eliminating the thinking errors being used to protect themselves from feeling the shame and guilt of accountability. Clarifying responsibility also confronts offender thinking errors of blame, minimization, denial, or rationalization. At the same time it is attempting to aid victims and caregivers in identifying and eliminating the misattributions that allow them to feel they caused or contributed to the offense. This realignment of responsibility is critical to the healing of all.

The offender is clinically helped to communicate a statement of responsibility. This focuses on communicating 100% responsibility for the choice to offend, and that the victim or caregiver is in no way responsible for the offense. This communication aids the offender in owning responsibility, while simultaneously aiding victims and caregivers in working through and eliminating misattributions of responsibility.

It is of critical importance that the professionals allow the offender to be entirely responsible for the choice to offend. It is recognized that multiple factors influence etiology of offending, and that a primary influence over the development of youth is his/her caregiver(s) and family environment. However, etiology is not causative. The etiological factor creates

vulnerability, but the individual chooses how to respond or deal with the vulnerability. This means that although familial issues may influence the development of the sexually offending youth, they do not cause the offending. It is important to help caregivers recognize the familial dynamics that may have influenced the abuse while also helping them to understand they did not cause the offender's choice to sexually offend. (Etiology is explained in more depth in Appendix 2.)

Additionally, victims need clinical support in sorting through their misattributions. It is not uncommon that victims feel they should have or could have dealt with the abuse differently, meaning they feel that they somehow contributed to the dynamics that allowed the abuse to occur or continue. Victims need clinical support in working through and disowning responsibility for the abuse.

Both caregivers and victims generally struggle to work through their abuse misattributions. This is significantly impacted in a positive manner when they receive a communication from the offender owning total responsibility for the abuse and relieving them of any blame. It is critical that this communication occur as early as possible in treatment.

This task is achieved as the offender communicates a responsibility statement, the victim and caregiver receive and process the statement with a clinician, and they are allowed to ask any clarifying questions of the offender. The offender then communicates an appropriate answer to the question. This creates a clinical dynamic in individual therapy where all participants must realign or reframe their belief of accountability for the offense. Healthy realignment allows all to benefit and progress in treatment.

Task: Acknowledgement of Wrongness and Harm Caused

The next clarification task deals with the identification of wrongness and harm caused. An important treatment task for offenders is the acknowledgment that their choice to offend was wrong, why it was wrong, that it harmed others, and an understanding of how it harmed others. Victims often question whether the offender truly knows the impact of the choice to offend, and whether the offender feels regret. This communication point allows victims to receive this answer while helping offenders understand the wrongness of their choice and how the choice caused harm.

One of the drawbacks to current offender treatment is, if the offender is removed from the home and placed in a treatment program, he/she often never sees firsthand the pain caused to the family and victim. This is also enhanced in the isolated treatment approach, where victims and offenders are treated separately with little interaction.

Another drawback in treating adolescent or child offenders is that they are in the process of developing competencies. One of these developmental competencies is empathy. Empathy allows the individual to recognize the impact or harm caused to others and develop the corresponding emotions of regret or remorse. However, because youthful offenders are in the midst of their development, they should be viewed as developing empathy rather than having empathy. Youth need to understand what empathy is and the internal qualities and developmental competencies they must achieve to develop empathy, and then work towards using empathy to evaluate their offending behavior. This does not mean they cannot recognize the wrongness of the behavior and that the behavior harmed others, it simply means that there may be a disconnect between the cognitive ability to understand the harm they caused and an emotional expression of regret or remorse for having caused the offense. This disconnect may also impact the ability for empathetic responding in daily interactions with others. Therefore, it should not be assumed that

offending youth possess empathy, but rather are in the process of developing the capacity for empathy. As a result, when offenders acknowledge the wrongness of their choice to offend, and that the choice harmed others, professionals may not see the congruent empathetic emotions or response. This does not mean the youth does not regret the choice, it may simply mean the connection to their emotions has not been established, or that the capacity for empathy is still developing. It may simply be too early in the treatment process to expect this.

The task begins with the offender communicating a statement that the choice to sexually offend was wrong, and why it was wrong. It is then recommended that in completion of this task the victim, caregiver, and others impacted be clinically assisted in identifying and communicating a statement that outlines how the abuse harmed them. This provides victims with the opportunity to tell the offender how the abuse harmed and changed their lives. The victim may also indicate how he/she feels about the harm caused. Caregivers of the victim, even if they are also the caregivers of the offender, should also be clinically aided in identifying the impact the offense had on them personally, their family, and their child (the victim). Non-offended family members, including siblings and extended family or others impacted, also have the opportunity to communicate how the abuse impacted them. These statements are then communicated to the offender and aid the offender in understanding the pain caused. The offender is clinically supported in recognizing that the behavior created the harm outlined by those impacted. The offender then cognitively acknowledges this harm, and is clinically aided in connecting this to an appropriate emotion. The offender then communicates a statement that acknowledges the harm caused, and if possible how he/she feels about having caused this harm. The acknowledgement of harm caused is then offered to victims, caregivers, and others impacted (which must be clinically processed first). Victims and caregivers are then given the opportunity to respond and ask any clarifying questions.

If the victim is unwilling or incapable of providing an impact statement, then the offender's therapist should provide the offender with assignments and information that allows the youth to recognize general/common short- and long-term effects, trauma, and harm caused by sexual offending. This should then be used in helping the offender formulate a statement that helps acknowledge the harm caused, a definition of the possible short- and long-term effects, and how he/she feels about causing the harm. Even if the victim does not complete the impact statement, caregivers should be encouraged to do so.

Task: Clarification of Abuse Questions and Dynamics

The next task allows participants and professionals to clarify the abuse questions and dynamics. The abuse dynamics are constituted by defining why the offense occurred and those etiological factors that created the vulnerability within the youth. (See Appendix 2 for definition of etiological factors.) It must be understood how these factors impacted the youth to create the unique pathway to offending. Abuse dynamics also speak to those issues or influences that triggered or initiated the abuse and those factors that allowed the abuse to occur or be maintained.

The offender begins this task by identifying and communicating his/her etiological factors and the pathway to offending. This communication is typically directed to caregivers and, when appropriate, to the victim. The offender then identifies and communicates what factors triggered the offending and those factors that were used to allow the abuse to occur and be maintained. While this is being clinically developed, the victim's and caregivers' therapist is aiding them in identifying any questions they have about why the abuse occurred. These are then

communicated to the offender. The offender should then sincerely respond to these questions. Others impacted are also given an opportunity to ask clarifying questions regarding the offender's offense etiology, pathway, and abuse dynamics. It may also be appropriate for the offender to identify how these abuse dynamics are turned into treatment goals, and what he/she is learning to keep from reoffending. The task must also ensure that any questions victims and families have about why the offense happened are addressed. Although responsibility for the offense has already been addressed, often victims and family members, especially caregivers, may have lingering worries that something they did caused or contributed to the offense. This task provides another opportunity to address this and work to eliminate residual misattributions.

If the victim or caregivers choose not to ask any questions, or cannot identify any question about the abuse dynamics, it may be appropriate to have victims read over the commonly-asked questions list. If they continue to not identify any questions they want answered it may be appropriate for offenders to respond to commonly-asked victim questions. (See table 3-4.) This response can then be shared with those impacted.

Insert table 3-4 Commonly Asked Questions

Task: Addressing Restitution and Amends

The next clarification task presents the opportunity for those impacted to communicate to the offender their expectations and desires regarding restitution or amends. Victims and caregivers should be clinically supported in identifying what they feel is needed to heal and move on, or what they need in terms of restitution or reparation for the harm caused. These expectations should be clinically processed to assure that they are healthy and appropriate. Once identified, the expectations are communicated to the offender. The offender is then clinically aided in developing a plan to meet the restitution needs. This is then communicated back to the victim or caregiver.

Restitution or reparation needs may be defined as anything needed to heal and make amends. This may include apologies, service to others, commitments to change, payment for treatment or medical costs, and restoration of any property lost or damaged, etc. Clinicians need to aid participants in processing their expectations. This is critical to letting go of the offense (See Phase 6.) Participants must feel that justice has been served.

Clarification of Family Dynamics and Issues

This task is mandatory if the offender and victim are siblings and the family wants to reunify. It should also occur if they are not siblings, within their respective families. Clarification of family dynamics and issues should focus on unhealthy familial issues or concerns in an attempt to create a healthy home environment.

The identification of negative or unhealthy family dynamics and issues has already occurred prior to this point (Step 1: Family Assessment). This would now be the time to clarify these issues where each participant will be given an opportunity to verbalize his/her impression or opinion of the issue and its causes. Clarification of issues is simply listing all issues that need to be addressed or changed in proceeding phases.

Elimination of Barriers to Healing

Each participant should be helped to identify and clarify any barriers or issues that he/she believe are preventing the ability to deal with or heal the trauma caused by the abuse.

Professionals then discuss how the offender could aid in alleviating any barriers to the victim's or caregivers' healing. The offender is then helped to create a communication that helps change or ameliorate the barriers. The converse can also happen. A communication from the victim or caregiver may facilitate the offender gaining insight or eliminating a clinical barrier.

All professionals and participants must accept that one of the goals is to restore or create optimal health and functioning for each participant. This goal allows participants to aid each other in the healing process. This task can also serve to empower participants, especially victims and caregivers, while fortifying their strengths.

This is a list of potential tasks of the clarification process. However, professionals must be responsive to participants' needs. If there is another task that has not been identified here, professionals should create a communication to alleviate or clarify the issue.

Steps 4 and 5 are the same for each phase, like Steps 1 and 2 will only be explained in this chapter.

Step 4: Debriefing of the Phase

As the phase comes to an end, all goals, tasks, and communications must be clinically debriefed. This debriefing serves as an assessment of the impact upon the participants. It helps to prevent further harm, and allows professionals to determine if the process is benefiting the participants and should be continued, or whether it should be postponed, or terminated. It also assesses whether the needs and goals of the given phase have been achieved. Again, these decisions are based on clinical necessity, and the wellbeing of the participants.

Criteria for the debriefing session are as follows:

1. The participant's impression, interpretation, and perception of the communication are assessed. The professionals ensure these perceptions are accurate and positive, and if not, the participant receives clinical help to reframe them.
2. An assessment is made of how the communication impacted the participant. Professionals then ensure that the participant reframes the communication in a positive and beneficial way.
3. A determination is made of whether the needs and goals for the phase have been achieved.
4. A determination is made of whether the participant desires to continue with the process.
5. An assessment is made of any indicators of possible offender relapse or victim regression into trauma symptomatology.

It is recommended that all clinically-facilitated communication, or contact/visitation between the offender and victim be clinically debriefed. The debriefing session is critical to maintaining participant wellbeing, and to ensuring successful reunification.

Step 5: Closure Point

There can be multiple closure points based on clinical need, individual participant desire, and the wellbeing of participants. As each phase comes to an end, professionals must assess the clinical necessity of advancing to the proceeding phase. Participants are then clinically aided to evaluate their desire to participate in the next phase. Professionals and participants make a joint decision to proceed, postpone, or discontinue the process until identified issues can be addressed.

If participants desire to continue, they should advance to the next phase. If the decision is made to postpone, a plan to address issues and reinstate services should be developed. If the decision is made to terminate services, participants should advance to Phase 6 and be aided in bringing closure to the abuse experience.

This decision is individualized. Each participant should decide whether to continue or not. Professionals may find that one or more participants may choose to continue while some may not. This means that those who desire continued participation move to the next phase, those who don't, move to Phase 6. Even members of specific families may choose to continue while others may not. If this happens proceed as indicated.

Chapter Four

Phase 3: Resolution of Abuse Issues/Dynamics and Reconciliation of Families

Phase 3 has two primary goals; the resolution of abuse issues and dynamics and the reconciliation of families. Resolution separates issues into problems and questions while creating an intervention or way to solve, clear up, or settle those problems.

The resolution phase is prerequisite to any hope of reunification. It allows participants to resolve any issue creating barriers to healing and reunification. Reconciliation is defined as restoring to union and friendship after estrangement; settling or bringing to agreement.

The Center for Sexual Offender Management (1999) defines family reconciliation as, "…the therapeutic process that ends with the resolution of problems and conflict areas that prevent a family from having a healthy, non-abusive relationship. Family reconciliation must take place before family reunification can occur. Reconciliation may take place without reunification, although reunification should not occur without family reconciliation." (p. 10).

Jerry Thomas (2002) adds in defining reconciliation that it is, "…reached when the family reconciles family issues that have been destructive-both to themselves, to each other, and the circumstances." (p. 1)

In the case of sibling incest and intrafamilial abuse, it is critical that the family be helped in resolving any issues that prevent the restoration of relationships, roles, and love. It is believed that in most sibling incest and intrafamilial abuse cases the families will reestablish contact and relationships over time, whether clinical reunification occurs or not. Therefore, it is important that every effort be made to resolve familial issues and dynamics that complicate healthy functioning and relationships.

Therefore the two primary goals, resolution and reconciliation, are achieved through resolution of dynamics that impact personal functioning and well being (resolution), and the resolution of abuse issues and dynamics within the family that cause an inability to establish a healthy, loving family (reconciliation).

Resolution and reconciliation best occurs through a clinically-facilitated communication between the offender, those impacted, and family members. It is designed to be an open discussion of the offense, its dynamics, impact, and treatment. It is a clinical forum in which participants can make statements, discuss and express feelings, discuss the abuse experience and its impact, and work together towards understanding and resolving the offense (resolution). In this same forum individuals can identify, discuss, and work to reconcile issues that inhibit the family's health and functioning (reconciliation).

The communication in this phase is intended to help participants resolve, and heal the impact of the abuse, while also working towards creating a quality and healthy home environment. The significant difference between the resolution and clarification phase is that communication in the clarification phase is a sharing of designed and requested information and identifying issues and dynamics, whereas the resolution phase works to discuss and ameliorate these issues. The resolution phase allows participants to have a clinically-facilitated communication or discussion. This is an open communication between the offender, victim, and family members and must be based on developmental status of participants. This dialogue allows participants to resolve and bring closure to abuse issues, dynamics, and family problems. It

allows participants to confront the offender. It also helps families deal with and resolve barriers to reconciliation and healthy relationships.

The resolution and reconciliation phase begins once the clarification phase has ended. Participants must be carefully and clinically prepared and must have accomplished specific individual treatment goals or prerequisites prior to its commencement. (See Chapter 8.)

Participants must demonstrate the capability of participating in the defined resolution/reconciliation tasks. The resolution and reconciliation phase is a prerequisite to reunification of offenders, victims, and families. (The goals for this phase are outlined in table 4-1.)

Insert Table 4-1 Goals or resolution and reconciliation phase

Benefits of Resolution and Reconciliation

The resolution and reconciliation phase provides a forum to resolve and heal the trauma caused by the sexual abuse, and reconcile issues within families. It creates the opportunity for a clinically-facilitated communication between offenders and those harmed. The benefits of this phase are outlined in table 4-2.

Insert Table 4-2 Benefits of Resolution and Reconciliation

Steps to Resolution and Reconciliation

The following are the steps to the resolution and reconciliation phase. As previously stated, Step 1, 2, 4, and 5 are similar in all Phases. (For a description of Steps1, 2, 4, and 5, see Chapter 3.)

The Resolution and Reconciliation steps are:

Step 1: Determination of Readiness

Step 2: Assessment of Safety and Safety Planning

Step 3: Selection of Communication Points or Resolution and Reconciliation Tasks

Participants and professionals select the resolution and reconciliation tasks that best achieve the defined individual and clinical need of participants. The communication method must also be selected. It is possible for face-to-face sessions to occur in this phase, however participants must achieve the defined criteria prior to this occurrence. (See chapter 8.)

The selection of tasks or communication points is based on individual and clinical need and should not be used as a checklist. Once tasks are identified, the professional, most likely the victim's or offender's therapist, should aid the participant in creating the desired message to communicate (for each task), aid the participant in communicating the message, initiate and facilitate the communication, monitor the presentation of the message, supervise the communication, ensure that all communication is clinically needed and delivered in a healthy and appropriate manner, and ensure that the communication is focused and congruent with the selected task and goal.

Presented below are the potential communication points for the resolution and reconciliation phase.

Task: Ongoing Information Sharing

This task allows for the continued communication regarding individual treatment. The offender is allowed to communicate regarding his/her treatment progress and struggles, and what is being learned and changed through therapy. It also allows the offender to share location of placement and potential dates for discharge.

The victim is also allowed the opportunity to communicate regarding his/her treatment progress and struggles. This should only occur if deemed clinically necessary and beneficial to participants.

Caregivers and family members are allowed to communicate regarding their treatment progress. Any participant can then ask clarifying questions or engage in a dialogue regarding treatment issues.

Task: Resolution of Abuse Dynamics

This task is designed to resolve identified abuse dynamics. There are three components to the abuse dynamics; (1) those that identify etiology or pathway to offending; (2) those that triggered or allowed the abuse to occur or be maintained; and (3) those that identify or define the ramifications or harm caused by the abuse. This task allows participants to communicate and have an open dialogue regarding these dynamics. This communication can take place through the following tasks:

Task: Accountability and Confrontation of Offender

In the clarification phase responsibility was realigned, however if the offender continues to struggle with accountability for the choice to sexually offend, this task offers professionals and other participants the opportunity to confront the offender. Confrontation is used to hold the offender accountable and help him/her assume responsibility for the choice. It is not intended to belittle or demean the offender. It does allow participants to describe their experience, express the impact it had upon them, and how they feel about the offender and their experience of being abused. Caregivers and other family members can also define their experience and how it impacted them. This communication is then used to hold the offender accountable. It allows the offender's denial and thinking errors to be confronted by professionals and other participants.

If the offender has not accepted that the choice to offend was wrong or caused harm, professionals and participants can confront this through providing victim's experience and defining why it was wrong and how it was harmful. These firsthand accounts are difficult for the offender to hear and can be very impactful in helping define the harm caused. Participants are also given the opportunity to hold the offender accountable and seek elimination of any ongoing harmful interactions and behaviors. The difference in this step vs. the clarification phase is that in this step the communication can be expanded into a dialogue rather than a static presentation of facts. It is the dialogue that can help break through denial and thinking errors in helping the offender own accountability. This step can also progress into confrontation intended to hold the youth accountable.

The ultimate goal of this task is that the offender will accept full responsibility for the offense, its wrongness, and that it harmed others. It provides the offender with a clear and concise description of how the offending behavior harmed others. It allows the offender to accept past and current abusive behaviors and work towards stopping them, while committing to live an offense-free lifestyle.

If the offender is not willing to accept responsibility for the choice to offend, and that the choice was wrong and harmed others, then the process should be postponed until the offender can achieve this, or terminated if he/she cannot.

Task: Misattributions of the Victim, Caregivers, or Other Participants

Often victims, caregivers, and other participants have a difficult time eliminating misattributions of responsibility for the offense. If any participant is not able to eliminate these misattributions during the clarification phase, this task provides him/her with further help in doing so. It allows a communication between professionals, the offender, and the struggling participant. This direct communication or dialogue provides support to the participant in eliminating misattribution and disowning responsibility for the abuse. The offender plays the critical role in this when the offender is able to clearly define accountability and the factors that allowed him or her to make the choice to offend, and also clearly defines that the victim or other participant has no blame or responsibility for the offender's choice. The offender can then directly communicate in a dialogue with the struggling participant which helps absolve misattributions.

If the victim, caregiver, or other participant cannot realign responsibility by eliminating abuse misattributions, services should be stopped and the focus shifted to individual treatment until he/she is able to do so.

Task: Identification, Addressing, and Resolution of Abuse Issues, Dynamics, and Questions

This task is designed to create an open discussion between professionals and participants regarding the abuse dynamics. Again therein lies the primary difference between the resolution and clarification phase. The resolution phase allows for a discussion of the issues. The clarification phase was intended to identify these dynamics, while the resolution phase works to resolve or ameliorate them.

The task begins with the offender further providing, discussing, and answering questions regarding etiological factors and pathways to offending. The offender then identifies treatment needs and risk factors for recidivism. The offender acknowledges problems and addresses areas of needed change to be healthy. Offender must also address potential risks if he/she does not adequately address and change treatment needs. The offender can then identify what is needed to live a healthy abuse-free life and how caregivers and other participants can aid in achieving this. Finally, the offender identifies the red flags and risk issues and educates participants (specifically caregivers), on the intervention plan to prevent an unhealthy lifestyle. Participants are then encouraged to ask clarifying question and engage in a dialogue.

Professionals and participants then have an open communication regarding the influences, triggers, and factors that allowed the abuse to occur and be maintained. This can include both individual and familial dynamics. Problems and issues are identified and participants work with professionals to create an intervention plan to fix these issues. Participants are then aided in resolving the issues. All identified participants can participate in this discussion. However, good clinical judgment needs to be used whether this discussion is appropriate and clinically necessary for the victim's healing. Victims should only participate when it is determined that the information will aid in recovery or treatment. The presentation should be directed primarily to the caregiver or supervisor. It is vital that caregivers understand this information as they increase their ability to supervise the offender.

The harm caused by the offense is then discussed. The offender learns and is able to verbalize the harm caused. The offender is then helped to create a corresponding emotion of remorse and regret for having caused the pain, and in developing empathy. The victim, caregivers, and other participants must be satisfied that the offender truly understands the pain caused by the choice to offend sexually.

Task: Emotional Expression

A priority of this phase is to create a forum in which it is safe for participants to express emotions regarding the abuse and the offender in a healthy way. In this task the victims, caregivers, and others harmed are aided in sharing their emotions with the offender. Professionals must ensure that the sharing of emotions is positive and self-esteem enhancing for participants, including the offender,

The sharing of emotions is a critical step in healing. There are two parts to this, the sharing of the emotion and an empathetic response from the receiver of the emotion. This indicates the offender must be able to hear the emotion, interpret it, and demonstrate a healthy response (i.e. remorse, empathy, etc.).

The offender should also have the opportunity to express emotions. However, those emotions must be correct and congruent with the experience. It is not appropriate to talk about past pain or victimization issues; this task is specifically about the healing of those harmed. Offenders should only be allowed to express remorse for the choice to offend.

There is an appropriate time for the offender to identify his/her pain. This should happen in the identification of etiology factors or the pathway to offending step. At the appropriate time, expression of emotion regarding etiology factors should be received by the youth's therapist, and caregiver (if deemed appropriate). However, it should not be shared with the victim. It could create confusion regarding accountability.

Individual Treatment Goals

This task offers the opportunity for participants to help each other with the achievement of individual treatment goals through the parallel treatment process. An upcoming chapter, (chapter 8), will identify multiple treatment goals and how participants can help each other heal. In this task professionals and participants will define how the communication can be used to help. They will then define the tasks and communication points.

It is also important that participants express support and encouragement to each other in the achievement of individual treatment goals. This task can also offer the opportunity to review the progress that participants are making toward accomplishment of their treatment goals.

Apology

This task allows the offender the opportunity to apologize to those they have harmed. The apology should occur after participants have been carefully and clinically prepared and have expressed a desire to participate. The offender offers a sincere and authentic apology to those harmed. The apology should demonstrate understanding and acceptance of accountability for the offense, its wrongness, and harm caused. The offender must also demonstrate by their words, actions, and emotional responses a sincere expression of remorse and regret. This allows the offender to express empathy towards those harmed. The offender should then communicate sincere commitments to change.

Each participant is then allowed the opportunity to accept the apology. Acceptance of the apology does not necessarily constitute forgiveness. It simply acknowledges that the offender has apologized. Those harmed by the offense can choose to offer the offender forgiveness or not. Offering of forgiveness is not expected, however, true healing can only occur through the forgiveness process. True forgiveness is based on an understanding that it does not mean what the offender did was okay or right, or that it will be forgotten. Forgiveness is defined as a recognition of the wrong done, insight into the emotions and impact caused by that wrong, and a willingness to deal with and let go of issues caused by the abuse. It is an understanding that the offender and victim have the right to be happy; and to accomplish this they must take control of their life and move forward. Forgiveness is a cleansing and empowering process, which typically brings closure to the abuse experience.

Defining Relationships

This task deals with defining current and future relationships. It is designed to provide a forum in which participants can discuss relationship options. This task helps the participants choose the type of relationship they would like to have with other participants. This does not mean that a relationship will necessarily be established. However, it allows those impacted by the abuse to determine the type of relationship they want with the offender. If a relationship is desired, professionals will help the participant define the relationship. Professionals and participants will work to identify and resolve the barriers and dynamics that prevent a healthy relationship. They will work to heal traumas and pains within the relationship, and aid participants in restoring or creating the desired relationship.

Reconciliation of Families

The clarification phase focused on the identification of familial issues and dynamics. This task seeks resolution of familial issues and dynamics. The task first requires identification and discussion of familial issues that contributed, influenced, or acted as etiological factors in the offender's choice to sexually offend. This portion must include a discussion of all factors that allowed sexual offending to occur in the family, as well as familial dynamics that may have allowed, supported, hidden, or maintained the abuse patterns.

Following close scrutiny of these factors is the addressing and resolving of unhealthy family dynamics. This may include caregiver marital issues, unhealthy custody issues, familial cognitive distortions or unhealthy familial values or moral structures, negative or unhealthy familial or parental attitudes, negative parental behavior, negative discipline patterns, abusive parenting styles, negative or unhealthy caregiver or familial coping skills, negative parental supervision skills, inability to protect children from abuse, presence of abuse, maltreatment, or domestic violence, negative or unhealthy caregiver or familial perceptions of the victim or offender, negative or unhealthy relationships (parent/child, sibling, etc.), presence of substance abuse problems, unresolved mental health issues, and unhealthy reunification desires or expectations.

After resolving unhealthy family dynamics, professionals will aid caregivers in developing skills to provide needed functions within the family. These functions are discussed in Appendix 1. It should be noted that it is not the clinical task to create perfect families, but rather to identify issues and teach the family how to begin to resolve these issues. It is about helping families progress and achieve a higher level of functioning, thereby changing the environment to a healthier state.

Healing Trauma

The final identified task creates a forum that supports and encourages participants to continue to heal. In this task, supportive communication is created to help participants continue to work through abuse issues and dynamics. This is accomplished through support for achievement of individual treatment needs, communication to remove barriers to healing, and working to restore the dignity of all participants. It is the primary goal to restore each participant to their optimal or highest possible level of health and functioning.

This ends the identified tasks or communication points for the resolution/reconciliation phase. There may be additional tasks that have not been identified here. It is important that professionals and participants identify other issues or dynamics that need to be addressed, or that create barriers to healing and create tasks to help ameliorate them.

Step 4: Debrief the Phase and Step 5: Closure Point, are the same for each level. (See Chapter 3 for descriptions of those steps.)

Chapter Five

Phase 4: Reintegration

Reintegration is defined as forming into a whole again, bringing back together. The Center for Sexual Offending Management (CSOM) (1999) defines reintegration as, “gradual re-acclimation or adjustment to a non-supervised, less structured environment featuring opportunities to demonstrate new social skills and responsible decision making in support of community and personal safety.” (p. 18)

If the youthful sexual offender was removed from the family or community, reintegration into family, support system, and community is a vital component of treatment. Even if removal did not take place, reintegration still plays a role. Most families and survivors have a perception of the youthful sexual offender based on the moment of the offense or disclosure. This perception needs to be adjusted. The reintegration phase allows those impacted to observe the offender practice new skills which can allow for realignment of perception and development of trust.

Critical to success in healing for the offender is the establishment of a support network since skills learned in treatment do not readily transfer to the community. Bengis et al. (1999) stated, “Research indicates that the post-discharge environment is a powerful factor in determining the successful long-term adjustment of youth who complete treatment programs” (p. 51). Offenders should be taught how to generalize skills and knowledge learned in treatment into family, community, and peer groups. Successful reintegration is key to post-treatment success.

Youthful sexual offenders placed out of the home need a period of time to readjust and learn how to use newly acquired skills in a less structured environment. The reintegration phase focuses on this task by offering the opportunity to practice and develop skills allowing for realignment of perceptions others have through observation of this change.

Reintegration is offender focused. It is the reintroduction of the offender back into normality. However, professionals must consider how the offender’s reintegration will impact those harmed. It requires careful and clinical preparation of all participants. It also requires victims to be informed prior to reintegration services. A safety and supervision plan must be created and committed to by all participants. This plan must incorporate victim and family recommendations and desires. The plan should also establish guidelines that can be clinically monitored.

Some tasks in the reintegration and reunification (Phase 5), can occur simultaneously. Professionals can use reintegration tasks as a way to begin to reunify the offender back into the home.

If reunification with the victim or family does not occur, the offender still needs to complete the reintegration process prior to closure of services. (Goals for the reintegration phase are located in Table 5-1.)

Insert table 5-1 Goals of reintegration

Benefits of Reintegration

Reintegration is designed to aid the offender in a gradual, careful, and clinically-planned manner to learn to function in less structured and supervised environment. This is accomplished

as the offender identifies and develops outside interests, hobbies, goals, and life pursuits. The offender is also provided the opportunity to practice newly established developmental competencies, social skills, clinical changes, and intervention plans in a less-structured environment. The offender will also learn to generalize these skills from a clinical to a normal setting. As stated before, those harmed by the abuse are allowed the opportunity to observe changes the youthful sexual offender has made. This is a critical step in restoring relationships and trust.

Steps to Reintegration

The steps to the reintegration phase are outlined in the next section. Steps 1, 2, 4, and 5 are similar to previous levels and can be found in detail in Chapter 3. These steps, though not listed here, must be completed. The steps are:

Step 1: Determination of Readiness

Step 2: Assessment of Safety and Safety Planning

Step 3: Selection of Communication Points or Reintegration Tasks

Below are the tasks of the reintegration phase. Professionals and participants should select the tasks that best accomplish the identified reintegration goals and needs. Professionals must then aid the participant in creating the desired message to communicate for each task, aid the participant in communicating the message or activity, initiate and facilitate the communication/activity, monitor the presentation, supervise the communication/activity, ensure that all communication is clinically needed and delivered in a healthy and appropriate manner, and ensure that the communication/activity is focused and congruent with the selected task and goal.

Task: Development and Implementation of a Reintegration Plan

The reintegration of the offender needs to be a gradual and carefully planned process. Prior to any reintegration services professionals and participants must meet to develop a reintegration plan. This plan outlines the selected reintegration tasks, and incorporates the safety plan. Reintegration potentially creates the opportunity for unplanned contact with those harmed, therefore the reintegration plan must also state rules for informal or unplanned contact.

Reintegration into the family may also require contact with the victim. This contact should not occur until after the apology and reunification phase. The plan should identify supervision needs, rules and boundaries, establish adults to supervise reintegration activities, as well as parameters for supervisors. The plan should also identify timeframes, goals/activities to accomplish during reintegration tasks, and should outline a visitation plan for the youth.

Reintegration of the offender with the peer group is also important. The plan should outline this as well.

And finally the reintegration plan should address the manner in which the youth will practice and generalize newly-learned developmental competencies, social skills, clinical gains, and intervention plan in real-life settings.

Task: Identification and Development of Outside Interests, Hobbies, Goals, and Life Pursuits

Success of the offender is dependent upon the ability to understand how to live and pursue a healthy abuse-free lifestyle. Offenders must be taught and aided in defining and understanding how to achieve this. In this task, offenders should be helped in identifying healthy and pro-social interests and hobbies outside of treatment and the family. These interests and hobbies should allow connection with others and bring joy to life. Not only should these interests and hobbies be identified, but also the offender should be helped in developing skills or abilities to accomplish the interest or hobby and be allowed the opportunity to practice these newfound skills and abilities. Professionals, caregivers, and family members should support and help the offender in this endeavor.

The offender should also be aided in formulating a life plan. The life plan should identify educational and career goals, relationship desires (family, romantic, peer, etc.), what kind of person he/she would like to be, how he/she wants to treat and be treated by others, along with identified desired recreational and social pursuits, etc. This plan should outline achievable steps the offender can begin working on during the reintegration phase.

Task: Practicing Developmental Competencies

Successful reintegration of the offender is also dependent upon the youth's ability to achieve developmental competencies and obtain needed social skills. Each youth must develop and establish competency in each phase of development. This includes the development of emotional, social, sexual, cognitive, and spiritual competency. Development of these competencies requires the youth to successfully accomplish or master specific developmental tasks. A significant focus of individual treatment should be in aiding the youth in successfully accomplishing developmental tasks and establishment of developmental competencies. (Table 5-2 defines developmental competencies.)

5-2 Developmental competencies

Youth must also be given the opportunity to practice and refine their developmental competencies. The reintegration phase is designed to aid youth in this. The youth and his/her therapist should design activities within the community, peer group, family, or support system to help develop and practice developmental competencies.

Task: Development of Social Skills

Each youth must also develop social skills including interpersonal (relating or interacting with others), intrapersonal (regulating self or establishing self-mastery), and achievement skills (managing life on a day-to-day basis). (Examples of these skills can be found in Table 5-3.)

Insert table 5-3 Social skills

Individual therapy should work to help the youth develop healthy social skills. The reintegration phase is designed to help practice these skills. The youth should work in conjunction with his/her therapist to design activities that allow the practice of these skills in varying settings and with varying groups of people.

Task: Practicing Clinical Gains

Youthful sexual offenders also need the opportunity to practice their clinical changes in less-structured and supervised arenas. It is clear that treatment has positive effects on youth. However, the ability to take skills and changes made in treatment and generalize these to other areas of life may be less effective. As a result aftercare and reintegration of these clinical changes is critical. The reintegration phase should be designed to help the youth generalize clinical changes to other areas of life including family, school, work, peer group, etc.

In treatment, plans and strategies have been developed to intervene with negative thinking, unhealthy behaviors, problems, and issues. These strategies are designed to prevent re-offense and all other negative, criminal, abusive, or unhealthy behavior. Offenders need the opportunity to practice use of these intervention plans in less-structured and real-life settings. This occurs as the youth is allowed more freedom and opportunity in family, peer group, and community. This task is accomplished by the youth, in conjunction with his or her therapist and support network, creating a plan that outlines goals, steps, and activities to allow practice of therapeutic gains in a less-structured environment. This allows the youth to generalize these skills from a treatment setting to a normal setting.

Task: Opportunity to Observe Changes in the Youthful Sexual Offender

So often, especially when the offending youth is removed, victims and those harmed never have the opportunity to see the growth and change made by the offender. It is therefore important that victims, caregivers, and others harmed have the opportunity to see these changes. This is achieved when they are allowed to interact and observe the offender. This interaction allows those harmed to see the offender using new skills, acting differently, and treating them differently. This interaction can occur through a series of visitations. These visitations need to be progressive in nature, from clinical visits where interaction occurs in the clinical office or treatment program, in-program or clinical office unsupervised visits, visits in the community, then in-home day visits, followed by overnight visits. Again the youth, therapist, and family must create a plan with specific goals, tasks, and activities that allow for the observation to occur.

Task: Reintegration

The offender should then be helped to reintegrate into the community, peer group, and family. This requires the opportunity to interact and spend time in each. This time is spent practicing skills, building relationships, and restoring trust. It should be gradual, careful, and clinically planned. This reintegration requires a cooperative approach between the offender, clinician, supervision agent, and caregiver, where a written plan is developed and approved. This plan must include specific goals, tasks, and activities to assist reintegrate at all needed levels. This can include the community, work, school, family, peer group, and support group.

This represents the last reintegration task. Professionals and participants should identify any unaddressed area and develop a task to accomplish it.

Step 4 and 5, Debriefing and Closure are the same in each Phase. (A description of the Steps 4, and 5 can be found in Chapter 3.)

Chapter Six

Phase 5: Reunification

The fifth phase is reunification. The Center for Sexual Offender Management (CSOM) (1999) defines reunification as, "a gradual and well-supervised procedure in which a sex offender (generally an incest offender) is allowed to re-integrate back into the home where children are present" (p. 19). CSOM (p. 10) also defines family reunification as, "…joining again of the family. It is step-by-step process with achievable goals and objectives". Thomas (2002) defined family reunification as, "The systematic restoration of a family who has been shattered by sibling incest" (p. 1). The Association for the Treatment of Sexual Abusers (2005) defines family reunification, "…(in cases where the client has victimized a family member) is the process whereby the individual who has sexually offended re-establishes relationships with family members, including the victim(s)" (p. 53). Ryan and Lane (1997) indicate that reunification, "…involves the systemic restoration of the family relationships" (p. 396).

Reunification is therefore defined as reunifying or bringing back together offenders, victims, and families (both immediate and extended), who have been torn apart or harmed by the experience of sexual abuse, through a gradual, healthy, well-supervised, and clinically-facilitated step-by-step process. Reunification is the systematic restoration of relationships leading to reconciliation, rejoining, and reuniting of families. Reunification is based upon the successful accomplishment of defined and achievable goals and tasks by all participants.

Successful reunification requires the completion of foundational tasks. Meaning that healthy reunification of families impacted by sexual abuse is based upon their ability to successfully accomplish the tasks of clarification, resolution, reconciliation, and reintegration. Therefore, family members (offender, victim, caregiver, and other siblings), must work to rectify and resolve any unhealthy or negative issues and dynamics created by the sexual abuse, including the resolution of etiological and maintenance factors and the successful realignment of responsibility and healing of abuse impact.

Also, participants must have accomplished individual treatment goals and focused on increasing their individual functioning in a healthy, positive way. Unhealthy and negative family issues must have been previously identified and addressed. And finally, caregivers must have worked to strengthen their ability to provide the necessary roles and functions to the children. Once these tasks have been achieved families can be reunited. Any unresolved issues in any category can block the ability to successfully reunify. (Table 6-1 outlines the foundational criteria for successful reunification.)

Insert table 6-1 Foundational Criteria for Reunification

Most families of adolescent sexual offenders will reunite at some point with or without clinical support. If not done correctly, this contact or reunification can cause problems that will potentially re-traumatize those involved. Families need to be together, when appropriate, and youthful sexual offenders need to reunite with their families. Professionals involved in these cases need to make every effort to help with the reunification of these families in healthy and positive ways.

It is clear that some families should not be reunited. Some victims may choose not to meet with or reunite with the offender. Professionals need to have sound clinical reasons for not providing reunification services or for not helping families reunite. These clinical reasons should be based on the fact that reunification is counterproductive or unhealthy to the family or individuals, that the family or individual does not desire reunification, or that there exists factors that make it unsafe for the family or any individual participant. Counter indications for reunification will be discussed more in depth in chapter 9. Again families and participants should choose whether they reunify. The offender should also be allowed a choice, (this should be confronted unless based on sound clinical reasoning). Professionals and participants must recognize that family reunification is "one of many ways that families may resolve issues generated by the offender's abusive behavior" (Association for the Treatment of Sexual Abusers, 2005, p. 35). There are many closure points to resolution/reunification services. Each closure point needs to be selected based on participant safety, need, well-being, and best interest.

Professionals and participants must also be aware that prior to the commencement of the reunification phase, the majority of difficult work has been accomplished in previous phases. Therefore, the reunification session itself may feel like a letdown after the preparation and work has been accomplished. As Libov (2004) writes, "Victims, abusers, families, and even therapists often expect a great emotional experience in the reunification session, this is often not the case" (p. 3). Participants should be prepared for this.

The reunification phase should begin once the foundational tasks of clarification, resolution, reconciliation, and reintegration have been accomplished. The reintegration tasks of observation of changes and skills, visitation, and reintegration can occur simultaneously with the reunification tasks. (The goals for reunification can be found in table 6-2.)

Benefits of the Reunification Phase

The reunification phase allows families torn apart by sexual abuse to rejoin in a healthy and safe manner. It establishes a gradual, healthy, well-supervised clinical process to reunify these families. It allows the systematic restoration of relationship, love, roles, and trust. It allows families to reform based on standards of health and safety.

At this point the participants have been carefully prepared and have achieved the individual treatment tasks. (These criteria will be explained in chapter 8.) Family functioning has increased, and family members are now ready for the reunification tasks.

Steps of the Reunification Phase

The following are the steps to the reunification phase. Again it is critical to remember that if the tasks of any step cannot be successfully accomplished then reunification services must be postponed until the issue can be addressed and ameliorated, or terminated if not. Steps 1, 2, 4, and 5 are similar to each phase; however still need to be completed. A description of these steps is found in Chapter 3. The steps are:

Step 1: Determination of Readiness
Step 2: Assessment of Safety and Safety Planning

Step 3: Selection of Communication Points or Reunification Tasks

The following section outlines possible reunification tasks or communication points. Professionals and participants select the tasks that offer the best course of action for reunification. It is through these tasks that reunification is individualized to the needs of the participants.

Once the task is selected the professional must also aid the participant in creating the desired message to communicate for each task, assist the participant in communicating the message, initiate and facilitate the communication and monitor the presentation of the message. Professionals must also ensure that all communication is clinically needed and delivered in a healthy and appropriate manner, and ensure that the communication is focused and congruent with the selected task and goal.

Task: Restoration of Relationships

A critical step in the reunification of families is the restoration of relationships. Achievement of this task requires each participant to first desire to restore relationships. Often in cases where sexual abuse has occurred with its resulting harm, the desire for a relationship is impacted. Professionals may need to foster the desire to restore the relationship. This should never supersede safety risks or individual wishes. However, often the barrier does not lie in a desire to have a relationship but rather in the ability to trust the individual. The following are areas that should be given attention in the restoration of relationships.

Correct definition: Family members must be taught the correct definition of a healthy relationship. All family members must share this definition. The professional team must also make a determination that the definition is correct, healthy, and in the best interest of each participant.

Heal blocking issues: Participants must be aided in identifying, confronting, and healing any dynamics or issues that block the creation or restoration of the relationship. This should have occurred in the clarification and reconciliation phases. These issues also often affect the flow of love within the relationship. Relationships are based upon a love bond. This bond cements the relationship. It is critical that individuals be helped to restore or create this love bond with family members. The word create is used because often, in dysfunctional families, the love bond is not present or is distorted. The love bond must also be correct according to the nature of the relationship, meeting clinical and societal norms. This means that caregivers and children have a love bond that is healthy and normal, and that siblings demonstrate the expected bond. All individuals create love bonds in a unique way; it simply means the bond lies within healthy parameters.

Individual health: The dynamics and issues of the abuse experience must be resolved prior to restoration of relationships, removing barriers to healthy relationships. Each individual should have accomplished the identified tasks of the resolution and reconciliation phase. This includes achievement of individual treatment goals and the restoration of healthy individual functioning. Healthy relationships are dependent upon the health of the individual comprising that relationship, and needs to be based on the developmental status of participants. Individuals need to be performing at their correct developmental status, and need to be able to achieve relationships as would be expected of other children or youth the same age.

Attunement and Empathy: Participants also need to reestablish attunement and empathy. This represents an emotional connection between individuals. It indicates that individuals are not only sensitive or attuned to the needs, dispositions, perspective, and emotions of the individuals

with whom they are in a relationship, but are able to respond in an empathetic manner. It also means that the individual is aware of his/her personal impact upon other's emotions through communication and interaction, and seeks to have the most beneficial impact upon others. The ability to attune to and empathize with others is foundational to establishing relationships.

Correct communication patterns: Healthy relationships are also based on the communication patterns that individuals establish. Healthy relationships must be based upon healthy communication. Individuals need to eliminate negative, demeaning, or abusive communication, while increasing healthy and positive communication patterns.

Trust reestablished: A consequence of abuse is loss of trust. Healthy relationships require trust. Therefore, trust must be created or reestablished within relationships. This requires the processing and healing of issues that have damaged trust (not only the abuse but each issue that damaged trust). This requires individuals to heal the trauma caused by the incident, and correspondingly change the behaviors that caused the trauma. Through healing, the desire to restore trust can begin. This typically happens in therapy after the apology session. However, a desire to restore trust must be accompanied by observation of change in the offending family member. Participants should be informed of the time and patience it takes for trust to be established.

Healthy roles established: Healthy roles must be established. Professionals and participants should work to define the expected role. This includes the restoration of obligations, functions, and tasks associated with the role. Roles in relationship can include, parent, child, brother, and sister. The ordinal position of the role should also be taken into account; for example older sister, younger brother, etc. Communities, cultures, and families have normed the obligations, functions, and tasks for the specified role. These should be defined and agreed upon. The expected role with its accompanying obligations, functions, and tasks should then be restored.

Restoration of love: Each participant must desire and work to restore love for the other person. Within the majority of families affected by abuse, love for each other has always been present, and this love is typically unconditional. However, due to experiences, emotions, and issues caused by the abuse, love has been blocked much like a dam in a river. The object in restoring love is to deal with the experiences, emotions, and issues caused by the abuse, thereby breaking the dam and allowing the love to begin to flow again. Love and trust are different. Love can be restored without trust present, but for love to be maintained trust must also be restored.

In some families, love for each other was never taught or demonstrated. However, love can be created. Individuals of the family need to acknowledge that they need to belong to and be loved by others and allow feelings of love to grow.

Intervention plan: As individuals work to restore relationship they must be aware that issues and problems will arise in every relationship. These individuals should be clinically helped to develop and commit to follow an intervention plan that outlines a process for dealing with future issues and difficulties.

Moving forward: Healthy relationships depend on not being tethered to the past. This requires each participant to commit to letting go of the abuse and moving forward with his/her life. It is also a commitment to not allow the past abuse to impact the desired relationship.

Task: Creation of a Quality, Healthy, and Safe Home Environment

Healthy reunification is dependent upon the quality of the home environment. It is critical that professionals and participants work to create a safe, loving, and healthy environment for the

family. The reconciliation phase worked to increase the *functioning* of individuals, caregivers, and the family. This needs to be continued, with emphasis being placed on participants desiring and working towards developing a healthy and happy family. Remember, it is not the environment itself but the milieu established by the individuals of the family that determine the health of the family. Each individual member of the family must be committed to doing their part in the family. This includes developing and maintaining healthy relationships, communicating in a healthy way, being responsive and caring about the needs of others, and working to fulfill their role in the home in a healthy manner. There must also be a commitment by participants to interact and contribute to the overall healthy milieu of the home, to love and take care of each other, to resolve issues and problems in a healthy loving and non-abusive way, and to keep all family members safe. Participants must be resolved to ensure that all family members feel heard, valued, respected, and loved; to share in each other's life, joys and sorrows; and to behave and interact in healthy and safe ways.

Caregivers must be empowered to successfully perform the expected roles and functions in raising healthy children. They must be committed to developing the skills to teach and hold their children accountable, and to raise them to be healthy adults. Caregivers need to create a healthy forum for youth to grow, express themselves, develop self-worth, and learn to face and deal with challenges in a healthy way. This requires a plan, including the development or rules limits, values, and boundaries. Caregivers must also hold each child accountable for inappropriate behavior and interactions in the family. Caregivers must strive to assist youth with fulfilling their role within the family, being a functional family member, and to resolve issues that prevent healthy family interaction. As caregivers closely supervise each child, they can better ensure he/she is on a correct and healthy developmental trajectory, and intervene anytime an issue threatens to impact the child in a negative way.

Appendix 1 provides a list of the expected functions of caregivers. More than anything caregivers must value each child and teach the child to value him or herself. Caregivers must be attuned to the needs of the child and work to help the child grow, develop, and mature in a safe and healthy way.

Each family is different, as is their potential for growth. The goal of this step is not to create a perfect family. It is rather to develop an attitude within caregivers to recognize issues and problems and work to change them, to help families gain hope that they can change and improve, and then assist them in progressing, and striving to improve the family milieu, relationships, and functioning in a positive way. The majority of caregivers love their children and want them to succeed. They need to be reminded of this and helped to develop the attitude to support each child's growth and development.

Task: Ongoing Healthy Interventions and Safety Plans

This task focuses on the establishment of an intervention plan for continued commitment to health and resolution of issues. This is a commitment for continued clarification and resolution of all future issues and problems. It is a commitment by family members to continue to love, support, nurture, protect, and care for each other.

Professionals and participants should work together to create the intervention plan. The plan begins with definitions and commitments to the level of functioning and health the family desires. It then discusses potential problems and issues that could occur. This includes addressing potential risks of reoffense by understanding the offender's individual intervention plan. It addresses the vulnerability issues of the victim, and outlines a response plan to address any

slippage in the offenders healing or functioning. The intervention plan concludes with a familial plan to address future issues or problems within the family. This task defines a step –by-step problem-solving guide for the family to reference.

Reunification

After completion of the above tasks, the offender, victim and family can be reunified. This indicates that relationships have been restored, the home environment is safer and healthier for all family members, and an intervention plan to deal with ongoing problems and issues has been established. At this point, if the offender is not living in the home he/she is allowed to return, based on the gradual visitation schedule outlined in the reintegration phase.

A celebration of reunification should occur. This celebration is designed to formally acknowledge the restoration of the family, and the familial and individual commitment to live in a safe and healthy way. It is also the formal beginning of the closure phase.

Step 4 (Debrief) and Step 5 (Closure Point) are duplicated at each level. (See Chapter 3 for a description of the Steps 4 and 5.)

Chapter Seven

Phase 6: Bringing Closure to the Abuse Experience

The sixth and final phase deals with "letting go of" and bringing closure to the abuse experience. Letting go of the abuse experience indicates that individuals no longer view themselves, their life, others, or the world through the abuse. Sexual abuse is an experience that lies outside the normal parameters of experience. This means that when an individual experiences or perpetrates sexual abuse, they have a difficult time resolving and letting go of the experience. So often the individual feels tethered to the abuse experience. The course of his/her life circles around the abuse. Often the abuse becomes the center or focal point of life; it mistakenly can be used to define perceptions of self, others, and the world. Resolution/reunification is designed to help these individuals understand and heal the trauma associated with the abuse.

The final step comes in teaching participants to let go of the abuse by severing the tether and committing to move forward. It does not mean that the individual forgets the experience rather it means he/she will no longer be defined by the abuse experience, nor will it be allowed to affect perceptions of life, others, and the world. Healthy criteria are established for perceptions of self, life, others, and the world. Participants are given tools to move forward in life with hope and optimism.

So often in this phase the focus is on the victim and family. However, the offender has earned the right at completion of treatment to also let go of the abuse and no longer choose to be defined through the choice to perpetrate.

This phase also acknowledges and seeks closure of the resolution/reunification and treatment. It is a statement that individuals have completed the required tasks and goals and can now close out services. It is an encouragement to move on with their lives in a healthy way.

Remember, that Phase 6 can occur at any time. If individuals choose to move to this phase prior to completion of previous phases, the same goals remain in helping participants close and let go of the abuse experience. (The goals of closure are summarized in table 7-1.)

Insert Table 7-1 Goals

Benefits of the Closure Phase

The benefits of this phase include aiding participants in letting go of the abuse experience by helping them learn to no longer view themselves, their life, others, and the world through the experience of the abuse. As participants are taught to reestablish healthy criteria for life, they can approach life in an empowered, hopeful, and optimistic way. A secondary benefit is the ability to bring closure to the abuse experience and to learn to move on with life no longer tethered to the abuse.

Steps of the Closure Phase

The following steps define the final phase. Because this is the last phase, there are some differences in the first steps as addressed below. Although this task is recommended for all participants, if someone chooses not to participate they should not be forced to do so. However, the benefits of participation should be clarified for the individual.

Step 1: Determination of Readiness

If a participant has opted not to participant in a specified phase, they should not begin the closure phase until professionals have assessed that the impact of the abuse has been adequately healed. Opting out of phases is more about honoring desires of participants in not having communication or contact with the offender, or choosing to not reunify with the offender or the family. It should not excuse the participant from working through completion of individual treatment goals. Participants need to be reminded of this, and helped to attend individual treatment to restore optimal level of functioning.

Step 2: Safety Planning

This represents the final safety plan. Care needs to be taken to create a plan that can be used into the future once services have ended. There are two types of plans that can be implemented at this point. The first is an individualized intervention plan and the second is an intervention plan for families. These two plans can be further differentiated as an intervention plan for those that completed all phases and one for those that did not complete all phases.

Individualized plans are developed through the course of individual therapy. For the offender, the individualized plan represents interventions to live a happy, healthy, and abuse-free lifestyle. For victims individualized plans are geared to empowering them to live safe, healthy, and functional lives. If a participant did not attend treatment, professionals should guide them in developing a plan that moves them forward in a safe and healthy way.

Families that completed the prior steps of this program, created a safety plan in the reunification phase. This plan represents the safety plan that the family will use in an ongoing way. If a family chose not to participate, professionals need to help the family develop a plan for ongoing safety needs and concerns.

For the most part, the choice to not participate in the phases is based on the victim's desire to not reunify or to not have contact with the offender. This desire needs to be incorporated into the safety plan. No-contact and accidental-contact rules should be agreed upon and established. Additionally, the plan needs to address any concerns or fears of re-offense. The victim should be made aware that the offender has no choice but to complete treatment, and should receive an invitation to restart resolution/reunification services, or any specified task, at any time.

Step 3: Creation of Support

This being the final phase, professionals must ensure that all participants have a solid and durable support network. Therapy will be coming to an end. The clinician should convey to the participant that reentering therapy at any time is an option. The individual should be made aware of the opportunity for continued clinical advocacy and support. This also indicates that if an individual chooses not to participate, there is an identified professional that can be contacted if there are questions, if the safety plan is violated, or if there is a desire to restart resolution/reunification services.

Professionals and participants have worked together to create or restore relationships with caregivers, siblings, and extended family members. This needs to be solidified so that it will continue as services come to an end.

Participants should also have been helped to connect to a peer group or other important adults (teachers, coaches, neighbors, religious leaders, etc.). This allows participants to feel supported into the future.

Step 4: Selection of Communication Points and Closure Tasks

This section outlines the tasks for this phase. It is highly recommended that each participant complete the specified tasks. These tasks are individual in nature, and do not require a clinically-facilitated communication to complete. However, there are still points of connection in the tasks if desired. These will be pointed out.

Task: Closure of the Abuse Experience

By this point in the process the abuse experience has been identified, defined, discussed, resolved, and hopefully healed. If this is not accurate then the participant is not ready to close the experience. Success in this task is based upon participant readiness and willingness to let go of the abuse experience. Professionals should aid participants in understanding how the abuse experience played a central role in their life, and how they can now move forward after the work they have done. Victims, or those impacted, need to understand that the experience of the abuse should in no way cause them to have a negative or unhealthy perspective of themselves. They need to be able to create a definition of self free from the abuse experience. This can occur at any time, no matter which phases the individual participated in. They then need to examine how the abuse impacted their definition of life, others, and the world. Professionals should ensure these definitions are accurate and healthy.

By this point, offenders have worked hard to understand and change their offending patterns. They have a right to define who they are without any labels (e.g. sex offender, predator, deviant, etc.). Professionals should help these youth create a definition of self that does not contain any labels or elements of the abuse experience. They have earned the right to not define themselves by their abusive choice. Offenders need to then be helped to have accurate perceptions of the victim, their family, others, their life, and the world.

All participants should then be helped to identify and set goals for a life path that is free from the abuse experience. Participants should be taught to foster the hope and optimism necessary to believe they can accomplish and or be anything. Professionals must help the participant define a healthy path for their life and then set realistic goals for its achievement. The participants should then create a contract that defines their commitment to move on with their life in a healthy way free of the abuse impact.

A celebration of the closure of the abuse experience should then take place. Participants should be helped to define a way to say goodbye to the abuse and to celebrate their new pathway in life. This symbolism helps them bring closure to the abuse experience and embrace a healthy life path. This celebration can either take place individually, or in connection with the family.

Task: Self Forgiveness Process

Critical to closing the abuse experience is the ability of the participants to forgive themselves. This is an obvious step for offenders. However, even those harmed can benefit from completing this task. This task simply offers a process that helps bring closure to the abuse experience for all.

Professional should aid each participant in completing the self-forgiveness process. The task can either be formally completed through a written assignment, or informally through a

clinical discussion. The assignment can also be completed together as a family after the reunification phase. (The recommended steps of the self-forgiveness are outlined in table 7-2.)

If the individual did not complete all phases they still should be aided in completing the self -forgiveness process. Self-forgiveness is not dependent upon forgiveness of the offender. It simply recognizes a desire to return to health and no longer define self through the abuse experience.

Insert Table 7-2

Task: Letting Go

At this point, participants are ready to "let go" of the abuse. Letting go implies that each participant has successfully achieved the defined individual treatment goals and/or have successfully completed all phases of the resolution/reunification. Again, letting go for individuals who have chosen to not participate in services or in certain tasks is dependent only upon their completion of individual treatment goals. Completion of the task requires each participant to make a declaration of letting go which includes moving on with life, seeking after joy and happiness, and no longer dwelling on the abuse. This does not mean the abuse experience will be forgotten. That is not possible. It simply means the abuse experience will no longer be allowed to stand in the way of success. Each participant should then formally state he/she is letting go of the abuse. A symbolic celebration of this for youth is often important.

The resolution/reunification services are now closed. The individual is discharged from individual treatment.

Step 5: Debrief Closure Phase

This step represents the last professional assessment of participants. The professional assessment should indicate that each participant is ready for discharge from individual treatment and resolution/reunification services. This is dependent on the ability to ameliorate any issue whether individual or familial that will create problems. If this is determined, then closure is recommended. However, if there is an issue that could lead to re-victimization, or the presence of any unhealthy dynamic then the individual or family should be referred back to individual treatment, or to a previous phase.

Step 6: Closure Point

Each participant and professional must feel that resolution/reunification services have been completed or taken to its most productive point. If so, services are officially closed. Participants should be given assurances that they can contact professionals at any time if issues or problems arise. Participants are provided ways of contacting the professionals. This also means that individual treatment has concluded. Again, a celebration of the closure of resolution/reunification services and individual therapy is recommended.

Chapter Eight

Preparation of Participants for the Parallel Treatment Process

The Parallel Treatment Process

For many years youthful sexual offenders and victims of sexual abuse have been treated in a disconnected isolated way. Treatment specialties have arisen for the treatment of each specific population. This specialized treatment has often not advocated for communication between the offender and victim until the apology process which is often after months or years of isolated treatment. This isolative treatment may not be the most effective and efficient way of treating sexual abuse cases. Resolution/reunification uses a parallel treatment process.

The parallel treatment process indicates that there are common clinical themes in the treatment of youthful sexual offender and victims of sexual abuse. Many of the individual treatment goals are interrelated as are many of the individual treatment tasks and assignments. This interrelatedness creates a potential for clinical interaction or clinically facilitated communication between the offender and the victim. Clinically facilitated communication is designed to clarify or resolve identified abuse issues and dynamics, or specified treatment goals and tasks. These points of interaction are labeled communication points. Each phase has specified communication points. These communication points outline the issue, dynamic, or treatment task for that phase.

Therefore, the parallel treatment process advocates for a clinically facilitated communication between the youthful sexual offender and the victim. This communication is designed to aid both in accomplishing identified treatment goals and tasks. Above all, the parallel treatment process creates a therapeutic forum that facilitates the healing of all and supports effective reunification of families.

The parallel treatment process allows for the accomplishment of treatment tasks in a more effective and efficient manner, thereby allowing healing to occur at a faster pace. It creates a symbiotic forum that simultaneously empowers victims while increasing the accountability of the offender. It aids the offender in understanding the true impact of their actions while validating the victim's abuse experience. It allows victims to explore and express their emotions while aiding the offender in developing empathy. Overall, it encourages, supports, and facilitates the accomplishment of individual treatment goals and tasks for both.

The parallel treatment process is beneficial to both the youthful sexual offender and the victim as the approach to sexual abuse treatment is consolidated. This consolidation indicates that victims and offenders are no longer treated in isolation but rather through a clinical effort to communicate and heal throughout the treatment process. It is believed that this parallel process maximizes the potential for successful and healthy therapeutic closure for the offender and victim.

Communication Defined

Often when the concept of communication between the offender and victim is considered, professionals envision a face-to-face meeting. Victim(s) and offender may not be ready for face-to-face contact until they have been clinically prepared and have achieved specified treatment goals and objectives. A clinically facilitated communication may take on many forms. It could be a therapist-conveyed message, written or recorded (audio or video)

communication, or face-to-face session. The exact form of communication should be selected that best conveys the message while protecting the victim from further trauma. The method of communication is progressive in nature. Less intrusive forms of communication are used in the beginning but then progress to more dynamic forms as individuals heal and grow stronger through individual treatment.

Communication in the parallel treatment process takes on two forms: symbiotic and supportive. Symbiotic includes communication that is advantageous to both. Supportive includes communication that aids in the growth and treatment success of the receiver.

Symbiotic Communication

The following specific tasks are clinically beneficial or advantageous to both the offender and those harmed. These symbiotic communications help both participants complete identified treatment goals. They facilitate the healing process and allow treatment gains to be made quicker and more effectively. This section identifies and defines those communications that are symbiotic in nature.

Task: Abuse Occurrence

This communication is designed to accomplish two primary goals. Initially, the offender acknowledges that the abuse occurred and the victim and those impacted receive validation of the same. It is critical that offender quickly break through denial and acknowledge that he/she committed the sexual offense. It is just as important that victims receive validation for their abuse disclosure.

In a parallel treatment process one of the first assignments for the offender is to communicate to the victim an acknowledgment that the abuse took place. Often this assignment aids the offender in accepting responsibility for the abuse. In most cases, on some level, the offender never intended to do harm to the victim. When the offender understands that acknowledging the offense will aid in the victim's healing, the offender may more readily acknowledge the offense. In turn, when the victim receives validation for disclosure of the abuse it makes him/her less vulnerable to the development of abuse misattributions.

Secondly, the offender's and victim's statement of the abuse experience should be compiled and shared early in the treatment process. This provides a description of the abuse and the ability to examine discrepancies.

Task: Realignment of Abuse Responsibility

It is important to realign responsibility for the abuse. The offender must take responsibility for the choice to sexually offend in order to progress in treatment, while the victim must work to release responsibility. In this parallel communication, the offender is required to communicate the choice to offend to the victim and take responsibility for that choice. This holds the offender accountable and aids in breaking through denial and eliminating thinking errors that allows for blaming others and not accepting accountability. The victim benefits from receiving the offender-responsibility statement. It aids in assigning responsibility to the offender while confronting and eliminating abuse misattributions.

Task: Acknowledgement of Harm Caused

Success in this task requires the offender to take responsibility that his or her choice to offend harmed others. Simultaneously the victim is struggling with the issue of whether or not

the offender acknowledges that the abuse caused harmed. The offender's acceptance that he/she harmed others creates a motivation for change. It is also a critical step in the development of empathy. However if placed out of the home, the offender may not see the harm the offense caused, this communication allows those harmed to express to the offender the impact the offense had upon them, and thus is difficult for the offender to ignore. Often, emotional reactions are ignited within the offender that allows acknowledgement and understanding of the ramifications of offending. Additionally, victims are afforded the opportunity to confront the offender for having caused harmed. This empowers the victim. When the offender acknowledges that he/she harmed the victim, it can be healing to the victim.

Task: Clarification and Resolution of Abuse Questions and Dynamics

This symbiotic communication allows offenders, victims, and caregivers to work to clarify and resolve abuse issues and dynamics. This task requires the offender to answer the question of why he or she offended by identifying the etiological factors and pathway to offending. It provides the victim and caregiver needed information to understand the offender's choice, and provides critical information in creating safety and supervision plans. It also allows for a discussion of the issues that provide answers that the victim or caregiver may need to facilitate healing. This task serves to hold the offender accountable while providing families with knowledge about what must be changed to prevent the abuse from reoccurring.

Task: Clarification and Resolution of Unhealthy Family Dynamics and Issues and Reconciliation of the Family

Resolution of negative, abusive, and unhealthy family dynamics/issues can only occur through symbiotic communication. Each member of the family must work in conjunction with the others to identify familial issues and problems, and then, through a clinically facilitated communication, work together to resolve these issues. It is through this process that families torn apart by sexual abuse can be reconciled.

Task: Expression of Emotions

Successful healing of trauma is also dependent upon the ability of those impacted to express emotions in a healthy way. A symbiotic communication allows the victim and caregiver to express feelings to the offender about the abuse. This task is cathartic and healing. This also helps the offender understand the impact of the offense, and helps the offender develop empathy. The offender is also provided the opportunity to express emotions for having offended which is healing for the offender. It helps the offender commit to change, and serves to begin to establish relationships and emotional connections to those harmed.

Task: Apology and Forgiveness

This task allows the offender to communicate a sincere and appropriate apology. It demonstrates to those impacted that the offender feels sorry and remorseful for the choice to sexually offend. It also shows that the offender recognizes the impact and wrongness of the offense and is committed to change. The apology is healing for both parties and allows progression towards restoration of relationships and reunification.

Those impacted have the opportunity to accept the offender's apology and offer forgiveness. The forgiveness of the offender is vital in reunification of families. Forgiveness can also be healing for those harmed because it frees them to move on with their life.

Task: Restoration of Relationships

Restoration of relationships is critical to the success of reunification. This task aids participants in defining the desired relationship, working to eliminate barriers and issues that adversely affect the relationship, while reestablishing or creating healthy communication, attunement, and empathy. It also helps participants restore or create trust, healthy roles and expectations, love, and a plan to resolve future issues. This task is essential to restoration or creation of healthy relationships in families.

Task: Creation of a Quality, Healthy, Loving, and Safe Home Environment

Youthful sexual offenders and victims require a healthy home environment to succeed. After the devastation of sexual abuse, families need to be assisted in creating a safe, quality and healthy home environment that values, respects, loves, nurtures, and guides the youth's growth and development. This task helps each family member understand how to and commit to do their part in a healthy family. It teaches caregiver(s) the expected roles and functions they must commit to in the home. And finally, it establishes a standard of expectations for interaction and behavior, with a guideline and intervention plan to recognize and deal with issues and problems.

Task: Reunification

The tasks outlined for reunifying families also require symbiotic communication. This communication allows families to achieve needed treatment requirements and goals that allow them to reunify.

Supportive Communication

The second form of clinically facilitated communication is supportive communication. This communication between the offender and those they have harmed is designed to support the clinical achievement of the receiver. It allows the sender of the message to aid the receiver in accomplishing a specified treatment task or goal. It is designed to allow participants to encourage and support the individual change of each participant.

Task: Safety Planning

The safety of participants is critical. This task ensures that each participant can verbalize safety needs and concerns. It allows for the negotiation of a safety plan that protects each participant.

Task: Sharing of Individual Treatment Information

This task allows those harmed by the abuse to understand the disposition, placement, and treatment needs of the offender. Timeframes for completion and discharge are provided. This knowledge serves to reassure the victim. It also allows the sharing of individual treatment progress, struggles, issues and barriers in achievement of individual treatment goals. It provides a forum in which participants can support and aid each other in the accomplishment of these goals.

Task: Reintegration of the Offender

Although this phase is offender-focused, the communication and interaction in this phase allows those harmed to be prepared that the offender will be in the community and to observe the

changes in the youthful sexual offender. This observation is critical to restoration of trust and relationships.

Task: Closure of the Abuse Experience

This task allows participants to bring closure to the abuse experience. It allows the encouragement of each other in healing, forgiving, and letting go of the abuse. It creates a way in which participants can support each other in moving forward with their lives in a healthy positive manner. It offers the opportunity to celebrate the closure of the abuse, treatment, and the resolution/reunification services.

Communication Points

Clinically-facilitated communication occurs through identified communication points. Communication points define a clinical task or area of communication between the offender and the victim. It is designed to clarify or resolve a specific abuse issue or dynamic, or to allow the participant to accomplish an individual treatment goal. Appendix three (Communication Points and Possible Parallel Treatment Assignments) gives an example resolution/reunification steps and how communication should occur. It also outlines potential assignments and the order these assignments should occur.

All communication must be clinically reviewed prior to it being communicated. If communication is going to be face-to-face it must be practiced and reviewed in individual or group treatment prior to it occurring. Additionally, the victim has the ability to determine what personal information is communicated regarding treatment or the impact the abuse had upon him/her. It is the responsibility of professionals to help the victim make good clinical decisions regarding this.

Guidelines for Communication

Communication between the offender and those they harmed can be beneficial but it can also create a potential for further harm. Therefore, it is critical that all communication follow strict guidelines to ensure safe delivery.

The following guidelines are recommended:

Therapist should outline and clarify the objectives of the given communication message, that the message is:

Clinically monitored
Communication should be clinically initiated, facilitated, directed, and monitored.

Healthy and focused
Communication should be focused and congruent and lie within the desired goal in accomplishing the specific clinical task. It must be healthy, sincere, and free from misattributions or thinking errors, and the delivery method must be designed to aid in the healing of both parties, and achieve the best results for participants.

Victim sensitive

Communication must be in the best interest of the victim. Professionals should make sure it is sensitive to the victim's needs and vulnerability. The victim's clinical needs and desires must always be considered paramount.

Safe
Communication must be safe, voluntary, and designed to heal participants. At no time should the need to express a message supersede the participant's right to safety, or negatively impact individual rights. No undo pressure should be placed on a participant to communicate a desired message, nor should anyone be constrained to send or receive a message. Communication should also be clinically needed, healthy, positive, and beneficial.

No communication between the offender and victim should occur without both being assessed as ready, willing, and clinically prepared for the communication. This means that the offender or victim has accomplished the individual treatment prerequisites. Also, no communication should occur if there is any concern regarding safety. Communication should be halted or stopped if determined to be negative for any participant.

Tips for Conducting Face-to-Face Sessions

Face-to-face sessions between the offender and those harmed provide an excellent opportunity to facilitate healing. However, as stated earlier, it could also be a time when victim(s) can be further traumatized. As a result, it is vital that therapists prepare for each and every face-to-face session.

The purpose of the session is to work towards the healing or amelioration of the trauma caused by the sexual abuse. Therefore, the setting of the session must be supportive of that healing. The setting must be therapeutic in nature and all participants should feel physically and emotionally safe. Once the setting is selected, each participant must be informed and agree to the rules for behavior during the session. These rules are designed to protect participants and ensure the successful completion of the task. Rules should be provided to each participant prior to the session, and then reviewed as the session begins.

The recommended format for the session is as follows:

1. The lead therapist asks if participants are comfortable and feel safe. If not, modifications are addressed to achieve safety. (The lead therapist is typically the offender's therapist, because most often the message needing to be conveyed is from the offender. However, if the *victim* called the session or has an agenda, the meeting should be facilitated by the victim's therapist.)
2. The rules for behavior are reviewed.
3. The lead therapist then discusses the objectives and goals for the session, and presents the purpose of the meeting or designed task of the session.
4. The message is then presented in a healthy and sincere manner.
5. The lead therapist then reviews the message, ensuring that all points were made clear and were delivered in an effective manner.
6. The therapist or any participant can then ask clarifying questions. These questions are then responded to in a sincere way. The therapist should aid the participants in providing answers if needed. This can serve as a good teaching moment for all involved. This process continues in the session for a long as the lead therapist sees it

as productive and needed. Remember to stay on task, if there are questions that bleed into the next task, participants should be informed that this will be addressed in upcoming sessions.

7. The lead therapist should then summarize the session, helping participants review what they have learned, accomplished, or gained. The session is then concluded. It is recommended that a new session is not set until after the previous session has been debriefed. Once the debrief session indicates a positive response to the communication and each participant has been clinically prepared and willing, a new session can be scheduled.

Important items to keep in mind when facilitating face-to-face sessions:

1. Participants need to know they can end the session at any time. If they wish to stop, the session should be stopped; they should then meet on the side with their clinical advocate. The reason for stopping the session should be reviewed. If the issue can be addressed, the session can continue. If not, the session should be postponed until it can be addressed.
2. The comfort and safety of participants needs to be monitored throughout the session. Therapists need to be attuned to any signs of discomfort. It is okay to stop the session and review how participants are feeling and address any concerns prior to continuing.
3. The therapist has the right to stop the session at any time if the safety of participants is in question, if the rules have been violated, if participants are off task, if the session is getting out of hand, or if the session is no longer focused on healing.
4. The allotted time for the session needs to be scheduled so that there is time to cover and accomplish the designated task.
5. After completion of the session, it is critical that the therapist and caregiver(s) monitor the participants to determine regression into trauma symptomatology or offending patterns.
6. Sessions need to occur frequently enough to ensure that resolution/reunification services proceed smoothly and do not get off track.

Preparation of Participants

A key to success is ensuring that participants are carefully and clinically prepared prior to participation. Determining readiness has been previously outlined (see Chapter 3). Participants must also achieve the needed treatment prerequisites.

Each individual participant should have defined individual treatment needs. It is through achievement of these treatment goals that the individual heals and returns to healthy stability and functioning. Examples of these goals have been defined for victims (see Table 8-1), offenders (see Table 8-2), secondary victims (see Table 8-3), and caregivers (see Table 8-4).

Insert table 8-1

Insert table 8-2

Insert table 8-3

Insert table 8-4

Participants are clinically prepared through the completion of individual treatment goals. It is recommended that each participant attend and successfully complete individual therapy. It is highly recommended that the offender and victim attend treatment. Caregivers may attend conjointly with either the offender or victim. All other participants should have an assigned clinical advocate. As previously stated, often based on fiscal/time constraints, individual therapy may not be available to all participants. If not available, a clinical advocate (either the offender or victim therapist) can advocate for participant clinical needs.

Participation in a given phase should be determined by the progress on defined goals, assessment of any barriers effecting successful achievement of the clinical goals, and the clinical stability of the participant. Evaluation of effective treatment needs should take place prior to participation in a given phase.

The goals and tasks of the phase, and the manner in which the task will be communicated must be selected and understood prior to preparing the participants. The nature of the task and method of communication informs the professional of how to prepare the participant.

The timing of phases is also impacted by proximity and nature of the offender/victim relationship. This means that if the offender and victim are siblings, then services are likely to begin quicker. Also if the offender is left in the home with the victim then resolution/reunification must be started quicker to ensure safety and healthy interactions.

Preparation for participation as a secondary victim follows the same guidelines as preparing victims. Preparation of secondary victims is similar to primary victims. Participation in the phases is similar, if not the same, as a victim. Therefore, in preparing secondary victims all recommendations regarding primary victims should be followed.

The following is offered as a guide to understanding what individual treatment goals should be achieved prior to the commencement of the specified phase.

Phase 1: Team Building, Decision-Making, and Preparation

This is the initiatory phase. Participants need no preparation to participate. In this phase participants are informed regarding participation options, are made aware of the benefits of participation, and commit to participate. Participants remain in this phase until they and the professionals feel they are prepared and ready for the clarification phase.

Phase 2: Clarification

This phase is designed to help participants clarify specific clinical points. Because this phase is based in a parallel treatment process it requires communication between the offender and those harmed. Due to the need for communication it is critical that participants be clinically prepared for this phase. However, it is also important to remember that communication comes in many forms and the communication in this phase is designed to aid in accomplishment of individual treatment goals for each participant. Keep in mind that this phase is about clarifying issues rather than resolving them. The following recommendations are offered regarding participant preparation.

Offender Preparation

Prior to involvement in the Clarification Phase, the offender must be willing to participate in resolution/reunifications services, must have a willingness to help the victim, must

demonstrate the ability to comply with the therapist's requests and rules, and must be able to offer a full disclosure of the abusive acts. The offender must be able to acknowledge that the abuse occurred and work to identify the details of the offense. Often the assignment of communicating with the victim regarding the offense will motivate the offender to break through denial and acknowledge the abuse. Use of the court report or a statement from the victim may be helpful in aiding the offender to break through denial.

The second task requires the offender to accept responsibility for the choice to sexually offend. This acknowledgement must be free from any thinking errors of blaming, justifying, or minimizing. Informing the offender that this communication is critical to helping the victim heal often motivates him/her. If the offender fails to accept responsibility, this can be confronted by those harmed in the resolution phase. The failure of the offender in accepting responsibility for the offense, brings the clarification phase to an end and indicates a need for advancement to the confrontation in the resolution phase. If the offender *does* accept responsibly for the offense, this is then communicated to the victim, and the third task of clarification can occur.

The third task of clarification requires the offender to acknowledge the wrongness of the offense and the harm caused. The offender must be able to communicate the choice to offend was wrong and that it hurt others. This declaration is elementary in nature. It recognizes the impact on a cognitive level. The offender may not be at a point of empathy or emotional understanding or connection to the pain caused. This clarification assignment is not about gaining empathy or emotional understanding. It is simply recognition on the part of the offender that the choice harmed others, while providing the victim with an assurance that the offender does understand there was harm caused.

The fourth task of clarification is identification of the abuse issues and dynamics. The offender must also be willing to focus on identifying and sharing the etiology and pathway to offending, and a willingness to identify the trigger and maintenance factors of the abuse.

These primary tasks of clarification open communication channels that allow the completion of other tasks. The offender needs to be committed to change and willing to communicate with those harmed. This allows for completion of the future tasks including provision of information, safety planning, addressing restitution and amends, and assessment of family dynamics.

Victim Preparation

The victim plays a very different role in the clarification phase. The overall tasks of clarification are to aid in the victim's healing, acknowledge the abuse occurrence, realign responsibility, acknowledge wrongness and harm caused, and clarify abuse issues and dynamics. Therefore, the victim needs to be willing to receive and clinically process information from the offender in order to participate in clarification tasks. Victims should not be expected to reply to any of the communications. However, if they are willing, victims can aid in the treatment of the offender by providing information regarding their abuse experience. This can often aid the offender in acknowledging the abuse, accepting responsibility for it, and recognizing the impact it caused.

All clarification tasks should be offender initiated, meaning that ideally the offender offers the communication to the victim. This changes only when the offender is in denial, minimizing, rationalizing, or justifying issues around the abuse occurrence, not accepting responsibility or the wrongness and impact of the offense. If these issues are occurring,

participants can be moved to the resolution phase, and if victims and caregivers are willing they can then confront the offender regarding these issues.

Caregiver Preparation

Readiness of this phase should be based on an acceptance of secondary-victim treatment goals, and a commitment to work on and achieve these goals. Participation in the clarification phase requires that caregivers accept the authority/need for professional involvement, work collaboratively with therapist, supervision agents, and court representatives, and be willing to comply with rules and restrictions of the court, supervision, and clinical systems. Caregivers must engage in the process, and fully cooperate with all clinical assessments, interventions, and safety plans for themselves and their child. Caregivers must be fully aware of the options, goals, benefits, risks, phases and tasks of resolution/reunification services, make an informed decision for participation, and fully cooperate in preparing themselves and their child for participation.

The caregiver must also be willing to work to accomplish the defined tasks and goals of the resolution/reunification. These need not be completed prior to commencement of the clarification phase. However, the caregiver must be willing to work on them in a sufficient and healthy manner. Caregivers must also demonstrate a commitment to the safety of the victim prior to commencement of the Clarification Phase. This indicates they are capable and committed to take immediate action when safety issues and concerns arise, that they understand and are capable of recognizing offender risk issues and patterns, and are willing to confront and report any safety concerns.

Phase 3: Resolution and Reconciliation

Phase 3 has two primary goals; the resolution of abuse issues and dynamics, and the reconciliation of families. These tasks provide participants with the opportunity to resolve their questions, issues, and emotions regarding the abuse.

Offender Preparation

It is in the resolution and reconciliation phase that the majority of the treatment work occurs. It should be viewed as progressive in nature, with expectation that participants are willing and committed to work on issues. Participants should be working towards completion of treatment tasks. Below are recommendations for preparing the offender for this phase. It is willingness and commitment to change, rather than completion of the task, that qualifies the offender for participation.

Ideally the offender is committed to change, willing to aid in the healing of those harmed, and committed to resolving issues in the family. If this is the case, the offender can prepare for participation. This requires the offender to have made a complete disclosure of the abusive acts, accepted full responsibility for the choice to offend, and has eliminated thinking errors that excuse, blame, minimize, deny, rationalize, or justify the offending. (Discrepancies between the offender and victim story should be resolved as best as possible, although complete agreement is difficult to obtain.) The offender must also acknowledge that the sexual abuse was wrong and harmful to others. This is a *cognitive* not *emotional* understanding of harm caused. (The offender is clinically working to understand the harm and how he/she feels about it, and is on the pathway to developing empathy.) Etiological factors and pathway to offending have also been identified by the offender, as well as triggers and maintenance factors that allowed the abuse to happen and continue. The offender should also be working to identify all unhealthy behavioral patterns,

need-attainment strategies, emotional expressions, and achievement skills. He/she has identified and is working to heal personal victimization issues, and is not using victimization as a rationalization for offending (even if it was an etiological factor).

The offender must have a solid commitment to change offending behaviors and heal. There is also present a commitment to aid in the healing of those harmed. The offender has achieved or is working to achieve stability and self-regulation skills and is emotionally and behaviorally stable. The ability to control impulses and energy has been developed, and he/she is compliant the majority of the time. Elementary skills in identifying and disrupting unhealthy and negative patterns have been developed. The offender should also be able to recognize developmental failures and weaknesses and be working toward achieving developmental competency in all areas, recognize social skills deficits and work to develop healthy social skills, identify co-morbid mental health conditions and demonstrate stability and improvement in dealing with these issues, and possess a desire to improve the family environment, personal participation and healing (or ameliorating) issues in the family that are negative and unhealthy. Additionally, the offender should be able to work to improve self-worth and esteem, be on the pathway to empathy development, work to eliminate any unhealthy sexual values, attractions, thoughts, and behaviors, and increase healthy and positive sexuality. And finally, the offender should be working to create interventions and life plans to help deal with all treatment needs and create a healthy, positive life.

If the offender is denying, failing, or unwilling to accomplish the identified treatment tasks, it does not mean that the resolution phase cannot begin. It simply means that it must be more confrontational in nature. Professionals and other participants must work together to communicate messages to the offender that confront the denial, failure, or unwillingness to accomplish treatment tasks. This may include confrontation of responsibility, abuse occurrence and wrongness, and impact of the offense. It can be expanded into abuse issues and dynamics, and familial issues. Confrontational communication can often help the offender break through denial, failure, or unwillingness, and develop a desire to heal and cooperate with the process. Once the offender accomplishes the needed tasks, services can continue. If not, it may mean that services need to be terminated.

Victim Preparation

The Resolution Phase for victims is once again about being provided communications that aid in healing. Preparing for participation requires the victim to have a willingness and desire to communicate with the offender, and recognize that this communication will benefit him/her. No expectation of victim participation should be mandated beyond this. However, if the victim chooses, an interactive communication may be established that will allow resolvement of abuse issues and dynamics, expression of emotions, reconciliation of familial issues, reception an apology, and restoration of relationships. The majority of the work on resolution tasks is done by the offender. The victim is simply prepared to receive the communication, and then clinically chooses how he/she responds to the information. Therefore, victim preparation lies in developing a commitment to receive communication, creation of a clinical advocacy to evaluate the communication and determine whether or not to respond and if so how. Victim(s) can and should play an active role in the reconciliation processes. The victim should work with the therapist to identify and find resolutions to familial issues.

If the process necessitates confrontation of the offender, the victim should be clinically prepared to issue confrontational communications if he/she desires to do so.

Caregiver Preparation

Caregivers must state a willingness to continue to work on achievement of individual treatment goals. A sincere desire to accomplish the defined tasks of the resolution phase including, sharing of information, realigning offense accountability, aiding victim in eliminating abuse misattributions, resolving abuse issues and dynamics, expressing emotions, resolving individual treatment needs, presenting an apology, redefining relationships, healing the abuse trauma, and reconciling the family must also be demonstrated. Caregiver participation in this phase requires a sincere willingness to work on these issues.

Phase 4: Reintegration

The Reintegration Phase is designed to reintegrate the offender back into family, community, and support/peer group and provides an opportunity for the offender to practice the skills he/she is learning. It also allows victim and caregivers to view the changes that the offender is making.

Offender Preparation

In preparing for the reintegration phase the offender must continue to demonstrate a desire and willingness to change and heal. Progress must continue to be made on all clinical goals listed in the Resolution Phase. The offender must have progressed to a point in which he/she is safe to interact with the community, family, support and peer group. The offender must also be capable of accepting supervision from others in a positive way. Once these criteria are met, the offender should be allowed interaction in the community, and supervised interaction with family.

Victim Preparation

Preparation of the victim for this phase centers on aiding readiness for face-to-face contact with the offender. This includes willingness for formal contact, feelings of safety, and progression on individual treatment goals that allow interaction in a healthy way.

If the victim has not chosen to reunify with the offender, he/she needs to be made aware of possible sightings or contact with the offender and be prepared for this informal contact.

The victim needs to be prepared and willing to observe and accept the changes the offender is making by being clinically aided in what to look for and how to determine honest change.

Phase 5: Reunification

The fifth phase centers on the reunification of victims, offenders, and families. This phase requires face-to face contact between the offender and those harmed.

Offender Preparation

The offender must have made significant progress in treatment goals to be ready for reunification. Because reunification requires face-to-face sessions and opens the door for the offender to return home, as well as restoration of the relationship with the victim, it is critical that the offender is clinically prepared for this process.

At a minimum, the offender must have:

- Made a complete, accurate, and full disclosure of all abusive acts including all victims.
- Accepted full responsibility for the offense without the presence of any thinking errors.
- Fully accepted that the offense was wrong
- Acknowledged that the offense harmed others and possess a good understanding of how the abuse harmed others. Shows a developing congruent and clinically accepted emotion of remorse or regret for having perpetrated the abuse, as well as a developmentally appropriate level of empathy towards those harmed.
- Successfully offered an apology for offending.
- Worked to resolve all abuse issues and dynamics, including identification of etiological factors, triggers, and maintenance factors and pathway to offending. These issues and dynamics should have been communicated to other participants during the resolution session.
- Recognized unhealthy behaviors, need-attainment strategies, relationship and communication styles, inappropriate emotional expression patterns, and negative and unhealthy social and achievement skills.
- Worked through any victimization issues, and successfully accomplished the treatment steps for victim treatment.
- Accepted that he/she has issues and problems and have made a commitment to change these issues.
- Focused on the development and implementation of a healthy intervention plan. This plan addresses steps to control or eliminate unhealthy behavioral patterns, achieve developmental competencies, establish self-regulation skills, develop healthy social skills, improve and successfully manage co-morbid mental health conditions, improved participation within family, create healthy self-esteem and worth, establish healthy sexuality within developmental status, and develop appropriate general empathy for others. These interventions are formulated into a life plan that will prevent lapse or relapse, establish and achieve life goals and pursuits, meet personal needs, and live a healthy life.

It is critical that the offender has achieved these individual treatment tasks and has progressed to his/her treatment potential, within the given developmental status. This prepares the offender for participation in the reunification phase.

Victim Preparation

Preparation of victims is critical. For the first time in the process, the victim must have achieved specific treatment tasks. This does not mean that achieved treatment goals are not preferred prior to this. It would be preferred that the victim achieve treatment tasks as quickly as possible. In fact, the prior phases have been designed to aid the victim in achieving these tasks. However, at this point in the process, completed tasks have become mandatory prior to participation in this phase.

At this point, the victim should have:

- Made a full disclosure of all abusive incidents

- Received assurance and validation from the offender, caregivers, and family that the abuse indeed occurred.
- Recognized how the abuse was wrong.
- Eliminated all abuse misattributions of responsibility.
- Processed and reframe the abuse experience in a healing way.
- Clearly identified and expressed emotions regarding being a victim, feelings about the abuse, offender, and family.
- Learned to express emotions in a healthy way.
- Identified the impact the abuse had on his/her life and worked to heal or ameliorate this impact.
- Identified and resolved all abuse issues and dynamics.
- Identified unhealthy dynamics within the family and has or is currently working to resolve these dynamics.
- Stabilized the personal role and functioning within the family and is functioning in an age-appropriate and healthy way.
- Reached a point where he/she feels empowered, safe, and is working to successfully establish developmental competencies and healthy social skills.
- Worked and continues to work to enter a normative developmental trajectory.
- Reached a point of clinical stability and continues to work to achieve optimal level of functioning.
- Reclaimed his/her life by developing healthy interests, hobbies, life pursuits and goals.
- Reached a point of developing and implementing a healthy life plan.
- Resolved personal feelings and issues regarding the offender and is willing to reestablish a relationship.
- Accepted the offender's apology and offered forgiveness.

The clinical team must assure that sufficient progress has been made on these treatment goals prior to the victim's participation in reunification sessions. It is recommended that most treatment goals need to be completed prior to the session's occurrence.

Caregiver Preparation

Readiness for caregiver participation in the Reunification Phase requires completion of the individual treatment tasks, and a clinically-determined sufficiency in the achievement of the caregiver's tasks as outlined.

At this point in the process, caregiver(s) should have accomplished the following:

- Acknowledgment of the abuse, its wrongness and impact on victim(s).
- Healthy realignment of offender responsibility.
- Achievement of healthy resolutions to the abuse issues and dynamics.
- Understanding of the etiological, triggering, and maintenance factors of the abuse, and recognizing the offender's pathway to offending.
- Resolvement and reconciliation of negative and unhealthy issues within the family, and full support of the victim's and/or offender's achievement of individual treatment goals.
- The ability to provide the needed function and role within the home.

- The ability and commitment to take immediate action when safety issues and concerns arise.
- The ability to supervise and hold the offender accountable to change and function in a healthy way in home and community interactions.
- Recognizing risk issues and patterns in the offender, and know the offender's intervention plan.
- Establishment of healthy and open communication in the family.

Phase 6: Closure

Phase 6 is the Closure Phase. This phase brings a closure to treatment, the resolution/reunification services, and the abuse experience. At this point, participants have either successfully completed all prior phases, or have opted to move to Phase 6 from any earlier phase. Preparation of participants should reflect both possibilities.

Offender Preparation

The first possibility is that the offender has successfully completed all prior phases, has completed all individual treatment goals, and is ready for discharge from treatment. He/she has a desire to let go of the abuse experience and move forward with the tasks outlined in Phase 6.

The second possibility follows the line that the offender, or victim, or caregivers chose not to complete all phases. In this scenario, the offender should complete the following prior to moving to Phase 6. All individual treatment goals have been achieved and the individual is ready to be discharged from treatment. The offender is ready to forgive self and move on with life.

Victim Preparation

In the first possibility, the victim has successfully participated in all phases, has successfully achieved all individual treatment goals, and is ready to be discharged from treatment. He/she must also express a desire and willingness to forgive self and let go of the abuse and move on with life.

In the second scenario, the victim, or caregiver opted not to participate in services. Here, the individual should still complete phase six. To do this participant must have achieved all individual treatment goals, and have a willingness to forgive self and let go of the abuse prior to participation in the phase.

If the victim or caregiver opted not to participate and chose not to participate in individual treatment he/she should be helped to advance to Phase 6 and be clinically assisted to forgive self, let go of the abuse, and should be encouraged to accomplish all appropriate tasks identified in Phase 6.

Caregiver(s) Preparation

Caregivers are prepared for this phase once they have successfully completed the reunification tasks of restoration of relationships, created a quality, healthy, and safe home environment, and developed an ongoing intervention and safety plan.

Chapter Nine
Contraindications and Addressing Difficult Decisions

Professionals must make difficult decisions when conducting resolution/reunification services. This chapter is designed to discuss several of the most difficult decisions. It cannot cover all of them. When faced with difficult decisions professionals must rely on their clinical experience and wisdom and the combined experience and knowledge of the professional team. Resolution/reunification services need to always be safe, clinically beneficial and needed, and in the best interest of the participants and the community.

Removal of the Offender

The question of whether the youthful sexual offender should be removed from the home is difficult. These youth are still dependent upon their environment to guide, teach, and mentor their growth. Removal can impact this in a negative way. On the other hand, leaving the youth in the home may continue to place the victim or community at risk. In making this decision, it is clear that if the case requires removal, it is the offender that must be removed. As the Center for Sex Offender Management (2002) pointed out, "Optimally, it is the offender, not the victim, that should be removed from the home whenever this is appropriate," (p. 7).

Remember, in many sexual abuse cases, both the victim and the offender reside in the same home. NAPN (1988) stated, "Offenders should always be removed from the home when the victim is in the family unit" (p. 23). However, argument can be made for more flexibility in this. It is clear that removal of the offender will have significant and dramatic effects upon the offender, the victim, and the family. So removal must be based on the following clinical reasons.

1.) A clinical determination that healing of the victim, offender, and/or the family can only begin once the offender is removed from the environment. As the Center for Sex Offender Management (2005) wrote, the offender's removal, "…can also provide the opportunity and permission for other family members to make important and necessary changes in the overall structure and environment," (p. 8). At times, the victim or the caregiver needs a period of time away from the offender and a safe environment to begin to heal.
2.) If the risk assessment of the offender indicates that there is risk to the victim or potential victims and this risk cannot be reasonably controlled or moderated, then the offender must be removed from the home and possibly the community.
3.) If an assessment of the victim reveals that the abuse has significantly impacted ability to protect him/herself, and/or compromised mental health and functioning to a point where separation from the offender is needed to stabilize and deal with the impact, then the offender should be removed.
4.) If the realignment of responsibility is so unhealthy that it requires a major disruption to break through it, for offender, victim, or caregiver, then the offender needs to be removed. The offender's thinking errors may be so ingrained that more intensive treatment and supervision is needed. Or the victim's abuse attributions are such that separation from the offender is needed to eliminate victim responsibility. Or if the caregiver(s) is denying, minimizing, or justifying the offense, which impact his or her ability to supervise the offender or protect the victim, the offender must be removed.
5.) The offender should be removed if it is assessed that the caregiver(s) cannot provide a safe and healthy environment, including the ability to provide for the needs of the

offending youth, guide and direct growth and development, supervise and structure behavior, and love and attach in a healthy way.

6.) If professionals determine that the removal of the offender is necessary to allow changes within the family structure or functioning to occur, then the offender should be removed.
7.) Individual functioning of the caregiver can represent a reason for possible removal of the offending youth. If the caregiver(s) is not stable and healthy, and this impacts his or her ability to parent the youth then the offender should be removed from the home. This may include substance abuse issues, aggressive behavior, domestic violence, antisociality, criminality, other abuse issues, or mental health problems.
8.) If the offender has functioning issues including self-regulation, conduct or ungovernability problems, aggressive or criminal behaviors, or mental health issues that cannot be addressed in the home environment, removal is indicated.
9.) The caregiver's refusal to work cooperatively with the professional team in individual and or/ child treatment, as well as family treatment, could necessitate removal of the offender.
10.) The offender should be removed from the home if it is determined that a more intensive treatment setting is needed. This typically occurs when the offender has multiple unaddressed etiological factors, or fewer factors that have had more impact upon the developmental competencies of the youth. In these scenarios the youth is in need of more intensive treatment to address the vulnerabilities caused by the etiological factors, or to aid in individual development of more pro-social skills and developmental competencies. It may also be that the professionals have determined that removal of the offender is necessary for full engagement in the treatment process.

The Center for Sex Offender Management (2005) states, "The removal of the offender from the home serves multiple purposes. Of primary importance is the immediate facilitation of both the physical and emotional safety of the victim and any other vulnerable persons within the home. In addition this separation may create a safer forum that is conducive to the victim's ability to discuss the abuse and other concerns more openly. Removing the sex offender from the home also reflects an assignment of sole responsibility to the offender." (p. 8)

Therefore, removing the offender from the home should occur only based on good clinical wisdom centering on four primary issues: the offenders risk to reoffend, the victim's vulnerability and treatment needs, the caregiver's health, stability and capability to provide needed functions, and the offender's treatment issues and needs in conjunction with treatment intensity or method required to best engage the youth into treatment.

If the offender is removed from the home, professionals should keep in mind these youth are still in the midst of development and still growth-dependent upon their environment. As a result, the placement environment must be sensitive to the developmental needs of the youth and be designed to provide healthy structure, acceptance and validation, instruction and therapy in achieving developmental competencies, pro-social skills, and amelioration from the etiological factors and abusive behavior patterns.

Victim Removal

While in most cases it is optimal for the offender, not the victim, to be removed from the home, there are circumstances when it is clinically necessary for the victim to be removed.

Victim removal should take place if:

1.) The impact of the trauma was so severe that it has effected mental health and functioning to a point where a more intensive treatment approach to heal and stabilize is needed. It may also be necessary if the abuse has exacerbated existing co-morbid mental health issues to a point that more intensive treatment or structure is needed to stabilize or treat the issues.
2.) The home environment is considered unhealthy or unsafe based upon the caregiver's inability to provide the needed roles and functions in the home, or the caregiver's instability, or lack of health is an issue. It would also be necessary if there exists child abuse, neglect, maltreatment, or domestic violence issues.
3.) Caregiver is unable to supervise, control, and aid in the healing of the victim, or if the victim's functioning, self-regulation, and/or trauma symptomatology is above the ability of the caregivers to care for, structure, and/or supervise.
4.) The caregiver's personal issues related to the abuse create an unhealthy or hostile environment for the victim. In this situation, the caregiver may refuse to acknowledge that the abuse occurred, or that the abuse was the offender's responsibility, displaying thinking errors that blame the victim, or minimize the wrongness or harm caused by the offense. Additionally, the caregiver's failure to acknowledge the offender's problem and need for treatment, or inability to see the impact of the abuse upon the victim and a lack of support to aid in getting the victim clinical help, or unrealistic expectations that negatively impact the victim would all be reasons for victim removal.
5.) The caregiver shows unwillingness, refusal, or incapability of working collaboratively with the professionals in the resolution/reunification services.
6.) The caregiver overtly or covertly demonstrates unwillingness to have the victim remain in the home.
7.) The caregiver is unwilling or incapable of protecting the victim from further harm, or is unwilling to support and supervise the victim as he/she heals the impact of the trauma. This may also be based on an observed, reported, or substantiated pattern of failure to protect the victim.
8.) The victim expresses fear or concern about physical well-being, and/or emotional health being harmed if he/she remains in the home. Or if the victim expresses that he/she cannot heal the trauma within the home.

Again, removal of the victim from the home *must* be based upon a good clinical rationale and is in the best interest of the victim. It must also be for the purpose of protecting, healing and returning the victim to a normative developmental trajectory.

If the victim is removed from the home because of caregiver issues or the nature of the home environment, then the offender, if present, should also be removed.

Participation in Resolution/Reunification Services

The clinical necessity of participation lies in very simple terms; it is in the best interest of the participant. The benefits derived by participation outweigh the risks. Participation will aid in healing and achievement of individual treatment goals. Most families will come back together at some point, and these services provide the best possible way to reunify or allow families to reunite.

Therefore, resolution/reunification services should begin once the professional assessment determines that it is in the best interest of the participant(s). However, there are multiple options, tasks, and closure points available. This allows professionals to individualize services to the needs of the individual and family. Therefore, professionals and participants are allowed the freedom to determine the course of services. Determination of which phases should be used are dependent upon the individual and familial need, and the potential goals and benefits that can be derived by participation in the phase. Each phase and its corresponding tasks must be determined as clinically necessary prior to their occurrence.

Resolution/Reunification Participants

All impacted by the sexual abuse have a right to participate in the process of healing the pain and trauma caused by the abuse. This includes the youthful sexual offender and all that were impacted or harmed by the choice to sexually offend. Individuals who can meaningfully participate in the process should. Age, development, and intellectual status can modify this. If a potential participant is too young, developmental or intellectual status will prohibit meaningful participation. Professionals should then be cautious about his/her involvement. However, if the individual can meaningfully participate and receive therapeutic benefit from that participation, he/she should be involved.

Involvement should include the offender, all primary victims, respective caregivers, and any other impacted individual(s) wanting to participate. Rich (2002) stated that clinicians should consider the following for involvement, "… all custodial parents/guardians, other parents, step parents, foster parents, non-custodial guardians significantly affected by the abuse, non-victim siblings, if old and emotionally stable enough, other adult family members who were/are significantly affected by the abuse such as grandparents, uncles, and aunts, other same or near age relatives, such as cousins, who were/are significantly affected by the abuse, such as close family friends, other close members of the perpetrator's community who may serve as important safe guards and support following the offender's return to the community, the victim's therapist, or other family therapists," (pp. 8-9).

This creates several potential participants. In fact, as Rich (p. 8) wrote, "The variations are simply to extensive and too diverse to resolve, and inclusion has to fall in the decision making realm of the clinician conducting the victim/abuser sessions."

Professionals should consider all potential participants, then make a clinical decision on who would benefit from participation, who needs help in resolving the impact of the abuse, who is capable of meaningful participation, who is needed to aid and support the healing process of the victim, offender, and family, and who needs to participate to make needed changes in the familial environment.

Timeframes

This decision of specifying the timeframe for reunification services is a process-oriented decision rather than an outcome decision. Professionals must be less interested in the outcome and more interested in the process or achievement of defined tasks and individual treatment goals. As a result, the timeframes are defined by need, completion of tasks, and achievement of individual treatment goals. The rule of timeframes is that any phase should only begin when clinically necessitated and participants have been adequately prepared. Timeframes must be flexible enough to accommodate individual and familial needs, and must be driven by individual and familial achievement on previous tasks and treatment goals. As Thomas wrote (unknown

date), the timeframes are "… determined by the idiosyncrasies and complexities of the issues of each specific case" (p. 1).

Victim Lacking Access to Individual Treatment

The current system often neglects the clinical treatment of victims of sexual abuse. Resolution/reunification services work better when victims are in treatment. The Center for Sex Offender Management (2002) stated that, "In cases in which the offender, family, or victim refuse treatment or intervention, reunification should not occur" (p. 2). However, victim's non-attendance of therapy is probably less about their resistance or refusal to attend but rather about parent's naiveté to the value of treatment. There are no clear symptoms that typify child sexual abuse. The California Coalition on Sexual Offending (2002) wrote, "A significant percentage of children are asymptomatic at disclosure" (p. 7). The parents of victims may not clearly recognize the value of treatment for their child. They may also have misperceptions that talking about or reviewing the abuse may further traumatize their child. Parents should be helped to understand that treatment is beneficial and will not harm their child, and that resolution/reunification services are more successful when victims are in treatment. It must be made clear to parents that resolution/reunification services is their family's best path to healing. Often when treatment is approached in this way, parents recognize the value of child participation. Systems should place a higher value on the treatment of victims.

A parallel treatment process also works better when victims are in treatment. Systems need to create ways to allow victims to attend treatment. Because there are no treatment mandates for victims there are often no funds to pay for treatment. Often families cannot financially afford treatment for their child. Systems need to work to create treatment services, and treatment funding for victims.

If a victim is resistive or refuses to attend treatment, there is no value in forcing them to attend. Forcing a victim to attend treatment is counterproductive and may mirror their victimization experience. At no time should a resistive victim be forced to attend treatment.

If a caregiver is resistive to having their child victim attend treatment, even though the benefits of treatment have been explained, the child should not be forced to attend unless it is professionally assessed that the child is significantly traumatized and will not be able to resolve this trauma without treatment. In these cases the Juvenile Court can be involved to determine if lack of treatment can be considered medical neglect.

Some professionals have advocated that services not be allowed if the victim is not in treatment, however, this may not address the problem of sibling and intrafamilial abuse. Most families will reunite over time. Families that reunite without clinical support may do so in an unhealthy way. It is dependent upon professionals to evaluate if terminating resolution/reunification services because the victim is not in treatment is in the best interest of the victim or family. If, after all attempts to engage the victim into treatment have failed, yet the family desires services, or the professional assessment indicates the family will reunite, then alternatives may need to be explored. It is the responsibility of professionals (specifically the offender's therapist) to help participants and families. The success of services lies in the ability of participants to achieve individual treatment goals, and the tasks of each phase. If a victim is not in treatment it impacts achievability of individual treatment goals. Yet establishment of the parallel treatment process can assist and provide therapeutic gain to victims. So even if not in individual treatment, participation in resolution/reunification services can still help victims heal. If the professional recommendation indicates that services should proceed despite the fact the

victim is not in treatment, then the resolution/reunification services may proceed. This is contingent upon a professional assessment that services are clinically needed and will benefit the victim. It must also be determined that services can be provided in a safe manner. If the decision of the professional(s) is to proceed, then the victim should be assigned a clinical advocate. This clinical advocate helps the victim receive the communicated task from the offender and then aids them in creating a response, if desired. This would be dependent upon the caregiver's consent to allow the child to participate. This process would clinically support victims that are not in treatment. The clinical advocate would aid the victim in learning and receiving therapeutic gain from communication points. It is best when the role of the clinical advocate is played by a neutral therapist. This can be someone in the offender's treatment program or agency, but is neutral to the family. The role of the clinical advocate can also be played by the offender's therapist. This is not ideal, but can work. This should not occur if it is determined that proceeding is not in the best interest of the victim, professionally contraindicated, or unsafe.

If a family or a child victim continues to resist services, this position should be honored and the family should be aided in completion of Phase 6, and then services should be ended.

Commencement of Offender and the Victim Communication

For years professionals have struggled over this decision. Historically it was determined that contact between the victim and the offender should either not occur or should occur only after years of treatment. In fact, no-contact orders were common. This decision has been approached with caution for years. Professionals have rightly felt that premature contact with the offender may re-traumatize the victim. As the Center for Sexual Offender Management (2002) wrote, "The easiest solution would be to simply prevent sex offenders from having any contact with children, this is simply not feasible; a more realistic approach, since many offenders will ultimately return home, is to provide intensive, knowledgeable, and preventive treatment" (p. 11).

Contact and communication between youthful sexual offenders and those they have harmed is inevitable because in many cases they reside in the same family, neighborhood, and community, or attend the same church or school. Also a lack of communication can work to solidly misattributions and trauma symptomatology in the victim, while at the same time creating accountability issues and lack of understanding of the harmed caused in the offender.

The difference lies in defining contact and communication. Communication in resolution/reunification services has been defined as sending and receiving a message related to a specific task, while contact is defined as being in the presence of. The resolution/reunification services are built upon multiple forms of communication, including a therapist-conveyed message, written or recorded message, or face-to-face contact. These forms of communication are progressive in nature. Victims and offenders begin with the least intrusive and work towards face-to-face contact (if appropriate). This communication is clinically facilitated and anchored. There are also different types of contact that can occur, including clinically-facilitated (occurring in a therapy session), clinically-supervised visitation (in program), chaperone-supervised visitation (in and out of program), unsupervised community visitation, and home visitation.

NAPN (1988) writes in referring to offender/victim communication that it, "… should only be considered in therapeutic framework" (p. 44). NAPN added that any contact (p.44), "… occur as a therapeutic decision." Therefore, the initial contact or communication between the offender and the victim must occur in a clinically-supervised manner, with clinical purpose and meaning and clearly defined treatment objectives and goals. The communication or contact must

be approved by the professional team, specifically the offender and victim therapist prior to its occurrence. The type of communication or contact should be varied and based upon the individual needs of participants and the identified safety concerns. The type, frequency, and amount of communication and contact are determined by all involved. Communication between youthful offenders and those they harmed should begin as quickly as individuals are assessed, prepared, and ready for the given task or communication point. Communication between the offender and victim can result in therapeutic gains for both. Contact should occur as participants make therapeutic gain and proceed in the delineated tasks and should only occur when deemed beneficial and clinically needed.

Commencement of Face-to-Face Contact

While communication methods are varied, often the mistake is made of assuming that when offender and victim communication is referred to, it is face-to-face contact. This is not always the case. Face-to-face contact never needs to occur to complete the resolution/reunification services. However, once participants are ready and prepared it may occur. NAPN (1988) wrote that, "Victim/offender sessions [face to face] are necessary in cases where siblings are to be reunited" (p. 44). This is certainly accurate in cases where the victim will have a relationship with the offender, or will have contact with the offender in an ongoing basis. In these cases, face-to-face sessions are critical to healing, reintegration, and reunification. Face-to-face sessions must be clinically initiated, supervised, and facilitated, and have clearly identifiable tasks, treatment goals, and objectives. Also, these sessions must follow a clear outline and have precise rules that are reviewed with participants prior to the session. While it is clear that all participants will most likely enter the session with a great deal of trepidation. However, if successful, the session can serve to ameliorate the tension and allow the healing work to begin. Face-to-face sessions offer a great opportunity to the victim in resolving abuse issues and dynamics, expressing emotions directly to the offender, receiving and potentially accepting an apology, working to reconcile familial issues while establishing a healthy home environment, observing change in the offender, restoring relationships, bringing closure to the abuse experience, and finally reunifying with the offender and the family.

As well, face-to-face sessions offer the offender the opportunity to express remorse and regret for having committed the sexual offense, to offer a sincere apology to those harmed, and possibly receive forgiveness. The offender can also work to reconcile family issues, and establish a healthy home environment. It also serves to allow the offender to show others that he/she has made life changes. The offender can work to restore relationships, reunite with the victim and other family members, and bring closure to the abuse experience.

Face-to-face sessions can occur at any point in the resolution/reunification sessions; however it is not recommended that the face–to-face sessions occur until the resolution phase. This is dependent upon the individual dynamics of the abuse. If the offender remains in the home with the victim, then face-to -face sessions should begin as quickly as participants can be prepared. However, if the offender is not in the home with the victim then face-to-face sessions ideally should not occur until just before the apology session. It is recommended that the following tasks be accomplished in face-to-face sessions:

A. Emotional expression task
B. Expression of apology task
C. Reconciliation of families task (in family session after the apology process)
D. Resolution of abuse issues and dynamics

E. Restoration of relationships
F. Creation of a quality, healthy, and safe home environment
G. Reunification celebration
H. Closure of the abuse experience and celebration of that closure

Commencement of Visitation Between the Offender and the Victim

Visitation between the offender and the victim are critical to successful resolution/reunification services. Thomas (date unknown) states that, "Visits are trial affairs" (p. 7). She added (p. 7) "These [visits] are laboratories to test out new ways of communicating and behaving."

Visitation between the offender and victim can begin once the apology task has been successfully completed. Visitation should be gradual and progressive in nature. They must be based upon clearly defined ground rules and clinical objectives. The visits start off as brief, being clinically supervised, and become lengthier over time progressing to no clinical supervision. The Center for Sexual Offender Management (CSOM) (2005), writes, "It is incumbent upon the respective treatment, professionals working with the offender, victim, and other family members to establish collectively the boundaries and rules of conduct for these supervised contacts and to ensure that all involved understand these parameters" (p. 9). CSOM (p. 9) continues, "The frequency and duration of these supervised visits should increase over time, with the ultimate movement toward supervised contacts in non-clinical settings. Any changes in the structure of visits should ideally be the result of a collective decision making process to ensure that relevant information from all parties is considered". CSOM (p.10) added, "Once it has been established that the offender, victim, and other family members have responded favorably to supervised contacts in clinical contexts, the contacts are typically allowed to expand to more natural settings." And finally CSOM (p. 10) wrote, "A process of progressively increased contact between abused children, abusers, and other family members that evolves from planned, short supervised meetings toward the least restrictive living arrangement that ensures physical and emotional security for all children in the family."

Visitation should begin after completion of the resolution phase and once professionals agree that participants are ready. It is recommended that the first visit occur in a therapeutic setting and be monitored and facilitated by a therapist. Once participants demonstrate they can meet in a clinical setting under therapeutic supervision and feel ready for the next step, visitations should occur in a therapeutic setting without the therapist. However an identified and trained adult supervisor must be present. Ideally this would be one of the caregivers, however it could be another adult family member, another adult with a vested interest. The next phase of visitation should begin when the preceding phase has been accomplished successfully and all participants feel it is time to progress.

The next visitation is supervised community visits. These are typically structured activities for the offender, victim and family that allow interaction in a safe and beneficial way. It allows those impacted to observe the progress the offender is making in treatment. Professionals help the family identify the activity, and the objectives and treatment goals that need to be accomplished. The first community visits are short, typically no more than two hours. Once the family has successfully achieved the objectives of the visit, the time can be increased progressively to a full day visit. Full-day visits may actually occur in the home. Once the family has demonstrated the ability to manage day visits, overnight visits can be arranged. As with all initial visits, overnight visits are clinically structured, with clearly defined rules and safety plan

to oversee interaction and behaviors. The first home visit should be twelve to twenty four hours. Visits should always be supervised by an assigned and trained supervisor until after the reunification phase. With success, length and frequency of visits can be increased.

It is critical that all visitations between the offender, victim, and family must be clinically approved and directed. All visits must also occur under the auspice of a safety plan. Professionals and participants should meet together prior to the visit to identify safety risks and concerns and then develop rules that must be followed at all times to ameliorate these risks. Each participant must be clinically prepared and readied prior to the visit, and must clearly understand and commit to the goals, objectives, and rules for the visit. Visits should not occur prior to completion of the resolution phase, with corresponding individual treatment goal achievement. Supervisors of the visits should be carefully trained and capable of performing the identified supervision tasks.

Contraindication of Resolution/Reunification Services

Each case of sexual abuse presents with its own dynamics and issues, as does each offender, victim, and caregiver. There are times when services are clearly contraindicated. As Thomas (2002) wrote, “At times it may become very clear that full reunification would be counterproductive for the entire family, and unhealthy or even dangerous for the abused sibling, the abusive sibling, and/or other family members” (p. 1). Libov, (2004) wrote, “In many cases, the reunification process is not possible for a variety of reasons” (p. 4). The Center for Sexual Offender Management (2005) points out, “There are certainly cases whereby, as a result of the ongoing assessment process, the involved stakeholders may determine that reunification is no longer safe for the victim or other children in the home” (p. 5). It is clear that there are specific cases where services should not occur.

This section will identify issues and situations where resolution/reunification services for individuals or families are not recommended. Services should not commence if professionals believe there exists valid clinical rationale against it.

In evaluating the contraindications for services the same themes of participation arise. Services should not begin or should be postponed or stopped based on unresolved safety issues and concerns, difficulties in individual functioning of any participant, problems in familial functioning, caregiver’s inability to provide role and functions, and finally disagreements in the service delivery system.

Safety

Services are contraindicated if there are safety issues affecting any participant that cannot be adequately addressed. This includes the inability to protect the victim, potential victims, family, or community from further harm. Also included, is insufficient individual change that indicates further contact or communication would re-victimize, perpetuate, or solidify abuse dynamics and issues. And finally, non-compliance with the safety or supervision plan or required individual terms of the phases and tasks, should contraindicate services.

Individual Functioning

The inability to control or successfully ameliorate individual issues on the part of any participant can contraindicate services. This can include any participants’ unwillingness to change or participate, refusal to successfully complete or participate in treatment or

resolution/reunification services, and failure to complete the goals, phases, and/or tasks. It also includes their inability to achieve sufficient progress on defined individual treatment goals.

All participants must achieve sufficient progress on individual treatment goals for services to succeed; however, success is particularly based on the offender's ability to change harmful and abusive patterns, the victim's ability to empower and heal the trauma, and the caregiver's ability to be healthy, and provide needed roles and functions within the home. Therefore, services are contraindicated when the offender, victim, or caregiver(s) fail to achieve needed treatment goals.

Familial Functioning

Resolution/reunification services are contraindicated when the family's functioning prohibits healing and successful provision of services. The decision to not perform services may be based upon the presence of familial issues that place participants at risk. This includes unhealthy familial dynamics that would adversely impact participants, the presence of abuse, unresolved negative qualities within the family, and/or thinking errors that make services unsafe or unproductive.

The presence of unhealthy familial issue can postpone services. However, termination of services should only occur after a professional assessment indicates the issue cannot be changed, managed, or ameliorated, and its presence places participants at risk.

Caregiver Functioning

Resolution/reunification services are contraindicated when caregivers have made insufficient progress on their individual treatment goals, are ambivalent, in denial, uncooperative, or refuse to participate. It can also occur when caregivers are incapable or unwilling to supervise the offender and/or protect the victim, have failed to make necessary changes within the family to prevent further harm, or do not support change and healing in the victim and offender.

Disagreement in Delivery of Resolution/Reunification Services

Services are contraindicated when professionals are unable to reach agreement of the needs and clinical benefit of delivering services, or the services are task-focused rather than creating change and healing in the participants and the family. There also may be problems with the delivery of services including distance or location problems, lack treatment resources for victims and caregivers, or inadequate time to accomplish phases. Once all attempts have been made to ameliorate these issues and they cannot be changed, services are contraindicated

There is a significant difference between postponing services versus terminating or stopping the process. The presence of any of the above issues does not mean that services must be automatically terminated. They can be postponed. Professionals and participants should make all attempts in working to eliminate, mange, or control the issue or dynamic so that services can proceed. Resolution/reunification services are only contraindicated and must be terminated when the issue *cannot* be eliminated, managed, or controlled.

It is important to note that termination of services means that participants are moved to Phase 6. It also means that participants are referred to individual treatment with the expectation that they achieve individual treatment goals. As Thomas (2002) wrote, "… even when this is true [services are contraindicated], family members need to be able to resolve feelings of anger, hurt,

and mistrust, and move on with their lives" (p. 1). The Center for Sex Offender Management (CSOM) (2005) writes that services should be stopped, "… when the successive steps of the reunification process cannot be effectively completed, or when significant barriers arise, reunification should be abandoned as an immediate goal" (p. 11). CSOM (p. 11) also recommends that if services fail then a shift in the efforts of professionals must occur, emphasizing individual treatment of participants.

Therefore, all identified participants need to be aided in healing the pain and trauma of the abuse (through individual therapy), forgiving self, bringing closure to the abuse experience, and moving forward with life in a healthy manner.

Also, if for any reason services are terminated, participants, caregivers, and families should be cautioned against reuniting without professional assistance. As explained, most families will come back together, therefore, families need to be informed that reunification is best achieved through professional assistance. Participants, caregivers, and families need to understand that reconstituting without accomplishment of the resolution/reunification phases may lead to problems and potential risk issues. Families who desire to come back together at a future date should be encouraged to contact involved professionals for reinstatement of services.

Appendix One: Role and Functions of the Caregiver

There is no perfect family. It is not expected that caregivers achieve all listed roles and functions. However, it is important that caregivers understand the necessary roles and functions for raising healthy children, and then work to increase their own functioning in a many areas as possible.

Caregiver Roles

Given the nature of youth, each is dependent upon caregivers for the following:

- Physical needs
- Attuned attached relationships
- Protection
- Guidance, love and nurturing
- Structure and supervision as internal skills are developed
- Instruction in defining the initial norms, rules, values, and expectations
- Providing initial blueprints in developing perspectives regarding role, place, and value
- Initial beliefs about self, others, and the world
- Defining needs and needs-attainment
- Shaping the initial internal working model or life paradigm that dictates how life is faced
- Instruction on achieving developmental competencies
- Providing and modeling initial achievement skills for problem-solving, coping, decision-making, and stress and frustration tolerance
- Initial modeling of how to act, think, and feel.

The primary role of caregivers is to teach and prepare youth to enter adulthood healthy, competent, and happy. To accomplish this, caregivers must be able to:

- Provide a structured, safe, quality environment
- Provide quality attachments and relationships
- Teach and model healthy standards, expectations, and blueprints for living
- Establish, monitor, and enforce healthy boundaries, norms, and rules
- Provide feedback and consequence to the youth's behavioral and emotional expressions
- Provide knowledge regarding skills, developmental competencies, and life tasks
- Allow the youth to grow, mature, and practice developmental tasks and skills
- Support, guide, and nurture the youth's development and growth.

Caregiver functions

Condition of Birth and Growth

Caregivers must ensure healthy and safe conditions for the youth's fetal development and birth, and then to continue to provide a healthy and quality environment in which the youth can grow.

Provide a Quality Environment: the Stage for Development

The caregiver must provide the stage (environment) on which the youth develops. Kagan and his colleagues demonstrated that parenting behavior makes a large difference in the youth's developmental trajectory (Siegel, 1999, p. 20). Siegel (pp. 20-21) added, "… that parenting has a direct effect on developmental outcome." It is clear that developmental success or failure is directly influenced by the nature and quality of caregivers. As a result, for a youth to achieve developmental competency, it is important that the needed functions, qualities, relationships, and experiences required for developmental success are provided by the caregiver. This is not to say that a youth cannot rise above a negative environment and achieve success, it simply means that it is easier to succeed if youth are provided a healthy environment in which to develop. Additionally, when provided a healthy environment, youth are less at-risk for developmental vulnerabilities. The nature and quality of caregivers directly impacts and influences every stage of development. The family and its environment represent a child's primary developmental influence and provides the context of time and space in which development occurs (Thomas and Wilson Viar; Longo and Prescott, Editor, 2006, p. 515).

Provide Quality Attachments and Relationships

The second and perhaps primary function of caregivers is to provide quality relationships. It is critical that youth have the opportunity to experience positive, attuned, secure attachments and relationships with others. These relationships begin with caregivers, and then extend through the family, to peers, and others within communities, society, and world. Caregiver-Youth relationships are the most influential in the youth's life. Therefore, it is critical that the youth has healthy, mature, stable, and consistent caregivers. The following is a list of qualities/abilities that healthy, consistent caregivers should have:

- Sound and healthy cognitive structures, value systems, moral codes, and paradigms (hopeful and optimistic)
- Emotional competency, capable of understanding, dealing with, and expressing their emotions in healthy ways
- Emotional attachment and connectivity
- Abilities in reading emotional cues and empathetically responding to the youth in a healthy manner
- Social competency, possessing the ability to establish and maintain healthy relationships
- Ability to give and receive affection
- Stability, being committed to the child as well as to parenting, and being willing to attach to, care for, and love those in their care.
- Financial means that lend stability to the living environment
- Healthy relationship with spouse or partner
- Ability in controlling any mental health issues, substance abuse, criminal behaviors, or criminal or antisocial thinking.

The Caregiver/Youth relationship should allow the youth to feel loved, valued, and important. Caregivers should support, guide, and supervise the youth in developing his or her potential. It is through relationships that the other functions of the environment are provided. Relationships allow the youth to feel part of, belong to, and have importance within the environment, which aids in validating overall worth and significance. It also serves to help define the youth's role and place in the social context. Caregivers provide essential knowledge and

information and teach and model skills, competency, and behavior, and foster growth and development.

Qualities of a Healthy Environment

Caregivers must provide a familial milieu that embodies healthy qualities. Becoming a successful happy adult is easier when the youth has a healthy positive environment in which to develop. The presence of these positive qualities determines the nature and health of the environment. The number of positive qualities inherent in the environment influences the youth. Therefore, it is critical that the environment in which a youth is raised be defined by as many positive qualities as possible. A healthy environment should possess the following qualities.

Safety

The youth should be surrounded by a physically and psychologically safe environment that is absent of neglect and abuse. It indicates that the youth's physical and emotional needs are consistently met, and that safe relationships, in which the youth has no fear of rejection or harm, are provided.

Structure

The environment should be structured, stable, supervised, and organized. Healthy guidance, rules, boundaries, and consequences for the youth should exist. There should also be modeled healthy values and beliefs as well as a positive moral code. Consistent and healthy messages should be delivered by all caregivers. Responsibility and accountability should be taught through the process of discipline. The structure of the environment should also allow the youth to test autonomy against a secure structured paradigm.

Support for Efficacy and Mattering

The environment should provide the youth with relationships, messages, experiences, and actions that inform the youth that he/she matters and has worth. The environment should support the development of confidence and competence in the youth as well as support the youth's ability to reach his/her potential. It should consistently reaffirm that the youth is capable, competent, and matters.

Successful Integration

While the family has the primary influence on the youth, there comes a time when the youth needs to enter and successfully integrate into the other components of society including school, peers, friends, community, and culture. Caregivers must support and help the youth make a smooth and positive transition to all components of the environment. Caregivers must also be able to help the youth deal with any confusion experienced through interaction, relationship, behavior, or message encountered in this integration.

Protective Factor

Positive caregiver(s) serve as a protective factor, which protects youth against developmental failure, negative, unhealthy, abusive, or traumatic experiences, and negative aspects or components of the environment.

Support for Resiliency

Caregivers must help youth develop resiliency. The youth should develop the internal qualities and skills that allow him/her to bounce back from developmental failure, negative, unhealthy, abusive, or traumatic experiences, and negative aspects or components of the environment in a healthy positive way.

Understanding of One's Culture, Gender, and Ethnicity

Caregivers must aid the youth in understanding, accepting, and valuing personal culture, gender, and ethnicity. The environment should not only support the youth in recognizing expectations, roles, rituals, and obligations to successfully perform within one's gender, culture, or ethnicity, but must also guide the youth in appreciation and acceptance of that gender, culture, and ethnicity.

Appreciation for Roots

Caregivers must strive to provide an environment that anchors the youth to a sense of history, providing meaning in who the youth is and a recognition of where he or she came from.

Creation of a Healthy Learning Environment

Caregivers provide the context in which youth learn. The learning environment must be based on sound and healthy principles. It is through this environment that the youth gains the knowledge and skill needed to succeed and prepare for adulthood. It is the caregivers who establish the attitude and atmosphere for learning, and who model and teach the value and importance of education. Caregivers must also understand that learning is both factual and attitudinal in nature, and that youth learn through instruction, experience, and modeling. Caregivers determine the information and knowledge that the youth receives and how this information is presented, and therefore must work hard to provide consistent, congruent, and healthy instruction, and then hold the youth accountable to learn.

Provision of Needed Knowledge, Information, and Developmental Competencies

Caregivers have a responsibility to guide the youth in obtaining knowledge, information, skills, and developmental competencies. Caregivers play an active role in the education of the youth, guiding them in the developmental skills and competencies required for success, and in obtaining the necessary information and knowledge to succeed as an adult.

Provision of Healthy Role Models and Modeling Healthy Standards and Expectations

Listed in every step of teaching youth is the expectation that caregivers model the standards and expectations they wish the youth to achieve. Youth learn through watching and mimicking. It is important that caregivers become or provide healthy role models who demonstrate the standards and expectations the youth is to follow. If unguided, youth will select role models, thus it is the responsibility of caregivers to ensure that these role models are healthy, and if not, must help the youth reselect and emulate healthy role models.

It is within the environment that the youth finds and adopts initial blueprints for emotional expression, social interaction, cognitive paradigms (values, morals, and distortions), achievement skills (decision making, problem solving, coping, defense mechanisms, and need attainment strategies); initial perceptions of self, others, and the world; and personal blueprints for sexuality. Therefore, it is vital that caregivers establish and model healthy prosocial expectations and standards.

Provision of Supervision, Feedback, and Consequences

As the youth grows and learns it is essential that caregivers impose boundaries, expectations, and consequences. Youth need external structure and supervision to guide development. Feedback and prompts must be provided as the youth interacts within the social context, and matures in developmental competencies and internal cognitive structures. Youth also need to be held accountable through appropriate consequences. Consequences help to frame the inappropriateness of choices or behaviors, while teaching accountability and responsibility for thoughts, emotions, and behaviors. An important function of caregivers is to provide the youth with moral supervision and guidance.

Provision of a Healthy Milieu for Experience

The impact of experience on the developing youth is significant. Experience shapes the developing youth, and as a result it is critical for the youth's caregivers to provide a safe place for the youth to face, understand, interpret, and deal with life experiences.

Caregivers must work to protect the youth from negative, traumatic, or unhealthy experience; or if experienced they must support and guide the youth in facing and coping with experiences in a way that limits impact and creates resiliency.

Caregivers must also provide experiences that allow the youth to learn, mature, and grow; and that allow the youth to practice and establish autonomy and developmental competency. Experiences should then be provided that not only guide development along a healthy trajectory but teach the youth that he or she is meant to feel joy and happiness.

Creation of Stage to Practice

Caregivers are required to create a stage on which the youth practices maturing developmental competencies, skills, strategies, relationships, and life perspectives. Development requires the youth to evolve skills, knowledge, and approach to life, which necessitates encouragement of the youth to practice development in a safe, supervised, and regulated way. Caregivers should allow and supervise the youth's maturation in social, emotional, spiritual, and sexual competency. Youth should be allowed to practice new cognitive structures and moral codes in a safe way, while being guided in the establishment of healthy cognitive structures. Feedback and consequences should be provided when needed, allowing the youth to struggle and at times fail, followed with interpretation and learning from the experience, while supporting the youth's unique approach to life.

It is vital that caregivers allow the youth to explore his/her world and learn to become a successful adult, while ensuring that caregivers protect, guide, model, and support this growth.

Provision of a Milieu to Meet Human Needs

Each human has specific needs that must be successfully met in order to achieve health, success, and happiness. Caregivers need to provide a healthy milieu in which the youth not only learns about needs, but develops the skills and strategies to meet those needs. There are two types of needs. Those foundational competencies and skills required to achieve and succeed in life, and those commodities or goods that success in life is based upon. These achievement needs are based on what is required to be happy, healthy, and successful in life, and are defined by differently by each person.

Caregivers provide the stage upon which youth develop the foundational skills and competencies to meet these needs. In fact, caregivers provide the initial blueprints for need-attainment strategies, and have a significant impact of the youth's decisions regarding achievement needs (the required commodities or goods of life), and the strategies they develop to achieve these needs.

It is important that caregivers aid youth in first recognizing and prioritizing needs; second, help the youth develop those foundational competencies to achieve needs, while modeling healthy need-attainment strategies; third, aid the youth in selecting healthy pro-social achievement needs; and fourth, teach, supervise, and regulate the development of the youth's need-attainment strategies.

Instilment of Resiliency

Caregivers must support the development of assets, resilient qualities, and factors within the youth. It is important to remember that just as caregivers can influence the development of vulnerabilities they can also impact the establishment of resiliency. It is within the familial environment that the youth establishes internal qualities that define resiliency or vulnerability. Because this occurs within the environment, caregivers can encourage or discourage development of these qualities. It is therefore critical that caregivers provide the relationships, functions, and qualities needed to aid the youth in developing resiliency while discouraging development of vulnerabilities.

The previous functions are necessary in establishing a healthy familial environment. All are important and needed. The absence of one can create susceptibilities in youth. The more functions that are either provided inadequately, or not at all, increases the youth's risk potential and propensity. Therefore, it becomes the responsibility of each caretaker to strive to successfully perform each function. This correspondingly increases the potential that the youth will succeed.

Appendix Two: Etiology of Sexual Offending

Etiology is the study of causation and origin of the disease or problem. Etiology represents the starting point in the acting-out process. Etiological factors are those that create the susceptibility or vulnerability for acting out within the youth, and then lead to or prompt the causation chain (see Table A1). It is these factors that allow the youth to depart from a normal developmental trajectory and enter the pathway to offending. Therefore, etiological factors identify issues that cause or influence the beginning phase of acting out. An etiological perspective to treatment posits that acting out is merely an expressed symptom of deeper problems or vulnerabilities within the youth.

Insert table A1

Etiology of acting out lies in multiple and varied factors. Etiology is a complex issue that is contained within the totality of the youth's experience, development, needs, relationships, and environment. Rich wrote (2003), "The real explanation for juvenile sexual aggression consists of a complex and idiosyncratic overlap between individual psychological, sociological, and possibly physiological processes, mediated and shaped by the developmental learning environment" (p. 81).

Susceptibilities that lead to the pathway of acting out sexually are complex; and often it is not the variable itself but how the variable is internalized that creates the problem. As well, the interaction and combination of variables needs to be evaluated.

Over the past decade research has begun to identify those variables that act as precursors to sexually acting out. Therefore, it is becoming clearer that the variables that lead to acting out are identifiable, predictable, and potentially preventable. It becomes a critical task in the treatment of sexually-offending youth, to begin to identify and isolate those variables that will inform therapists about etiology, maintenance, recidivism, and importantly, treatment needs. As Fanniff and Becker stated, "It makes intuitive sense that if we can effect a change in the etiological factors related to non-normative behaviors, we will create a lasting change in the behavior" (Longo & Prescott, editor, p. 130). Identification of etiological factors may provide therapists with the ability to prevent sexually acting out prior to its occurrence. It therefore makes the treatment of that behavior more effective.

Any effective treatment model must consider the totality of the youth. Often the legal system, and potentially, the treatment provider react to the nature of the behavior rather than the causative or maintenance factors and the true treatment needs of the youth. This is understandable; for years it has been assumed that the first treatment goal with youthful sexual offenders is to prevent further abuse. This philosophy places the legal system and treatment providers in the position of community protector and forces the focus on the behavior itself. However, treatment becomes truly effective when all involved in the treatment of the sexually-offending youth begin to see all aspects of the youth's treatment needs. Treatment approaches must be developed that examine the youth's life experience, development, relationships, human needs, environment, and the influence these had upon the acting-out behavior. Rich (2003) stated it this way, "[There is a] need to recognize and understand human behavior in the context of individual development and life experiences, or with a phenomenological view in which we recognize that individual action is influenced by many factors, rather than single or universal causes" (p. 77).

Therefore, it becomes critical to recognize the complexity and uniqueness of each individual. Treatment content, process, and delivery can then be appropriately matched to that individual.

Identifying those variables that are precursors to the choice of acting out requires the ability to recognize that humans are constructed through a delicate interplay between biology, psychology, sociology, and environmental factors. There is no common set of characteristics, behaviors, traits, or other features that uniquely identify or flag potential acting out in youth. There is no typical profile for acting out. This indicates there is not one key variable, that if present, predisposes youth to sexually act out. However, research has begun to identify variables or characteristics that appear with some regularity in youth who act out. These variables are not necessarily causative and will not automatically lead to acting out. It is not that simple. The pathway to acting out is much more complex. These variables do not necessarily predispose the youth, but may act as precursors. The presence of the variable may begin an interaction within the youth that creates a susceptibility or vulnerability which increases the propensity to act out.

Research into the etiology over the past few years has begun to identify factors or variables that occur, with some regularity, in the history of youth with acting-out issues. Remember, however, as Rich (2003) points out, "Variables do not occur with enough frequency or consistency to conclude they are undeniable features of offenders or unique enough to be used to distinguish offending from nonoffending adolescents. However, variables and patterns are being noted with some regularity and we must consider them" (p. 39). Rich (p. 43) added, "It is reasonable to seek commonalities that allow us to spot danger signs for both development of juvenile sexual offending and continued juvenile sexual offending."

In beginning this process, there is no single or common pathway to acting out. In reality there are many pathways and multiple and varied motivations and causations. But there are common features that must be noted and researched to determine the effect they have on etiology. Etiology is individual and although the variable may be present, it is the impact upon the internal development of the youth that leads to acting out. As a result of this, there are countless permutations to etiology. It is the unique impact the variable has on the youth that must be understood.

Although etiology is individual, there are common factors that can create susceptibilities in youth. This means there is commonality in etiological factors. These variables are not discriminatory enough to separate youth with sexual-behavioral problems from youth with other types of acting out, or even from youth who do not act out. The presence of the variable does not cause acting out, however the presence of the variable requires the youth to resolve the impact it created in his or her life. It is in the resolution of the variable that a susceptibility or strength is formed, relying upon the presence or absence of protective and resilient factors, and nature and quality of the caregiver response. It is also in the resolution of the variable that a choice of pathway occurs. It is in this process that motivational factors impact choice of acting out. This also means that youth who sexually offend may not be that different from youth who choose other acting-out behaviors. Ryan and Associates (1999) wrote, "One cannot assume developmental or phenomenological similarity on the basis of either a referring symptom or the facts of the case" (p. 70).

Traditionally, youth with sexual problems have been isolated, viewed, and treated differently than other youth. It is becoming clear that there is crossover in etiological factors and similarity in causation factors in the history of youth with sexual-behavioral problems and youth with other acting-out behaviors. The difference in choice of acting-out behavior may have less to

do with the etiological variables and more to do with the unique life-experience of the youth, the resolution of the variable, and motivational factors acting within and upon the youth.

It is possible to begin to identify and isolate variables that create susceptibility to acting out. These variables allow professionals to identify danger signs in youth, predict high-risk potential or propensity, and pinpoint the etiological pathway to acting out with the corresponding treatment needs. Ward, Polaschek, and Beech (2006) talked of the clinical value of identification of variables when they wrote, "Identifying clinical phenomena gives valuable insight into the specific causes or etiological factors that lie behind his abusive behavior, and helps in the design of intervention programmes to stop him for reoffending" (p. 4).

Identification of variables allows clinicians to aid the youth in working towards resolution of risk conditions and acting-out problems. These variables do not cause, but instead increase risk-potential and propensity and the likelihood of acting out.

Etiological variables are multifaceted and uniquely individual. Jerry Thomas (2006) wrote about this when she stated, "We do not know what variables need to be present, in what combinations, in what relationships to each other, at what critical points of development, with what intensities, and in what context in order for sexual abuse to occur and be maintained" (Longo and Prescott, Editors, p. 527).

Using variables to identify etiology is a complex and difficult process. Rich (2006) wrote, "There are a myriad of reasons, too complex in their effects and in their interactions with one another, for us to ever fully comprehend why a troubled youth engages in sexually abusive behavior and another does not, or why some juvenile sexual offenders desist before they become adults and others become sexual offenders in adulthood" (p. 4). He added (p. 27), "There are no predetermined pathways that inevitably set into motion any particular behavior, including sexual aggression. Individual pathways are so complex and influenced by so many factors, both subtle, and obvious, that we may not be able to define a single pathway, or set of factors or events, that leads to the same behavioral outcome for every individual first stepping along a similar path".

It is clear that there is neither a simple explanation to acting out, nor an exact recipe to treatment. Understanding etiology is complex and complicated. It requires the following clinical skills and effort:

- Taking time with each individual youth to examine those variables that created the susceptibility
- Analyze the impact the variable had on the developing youth
- Deciphering how these variables, corresponding vulnerabilities, and internal processes impacted the youth and created problems
- Understanding how experiential and contextual issues within the learning environment exacerbated the impact
- Realizing how all of the variables combined to place the youth on the pathway to sexually acting out.

An etiological approach to treatment seeks to identify factors that create susceptibilities in youth. This model follows the theory that these susceptibilities influence and potentially change the youth's developmental trajectory. This change or departure results in a selection of a pathway, or new developmental trajectory, that leads to acting out. The factor that began the process is etiological in nature, having triggered a reaction that leads to acting out. The etiological model therefore looks to identify potential factors that can trigger the process.

Identification of etiological variables is a complex issue. All categories impacting the youth are connected. For example, development is interwoven through experience and environment. This must be considered in identifying etiology. Any factor must not be viewed as a standalone factor. All variables interact together within the youth to create the susceptibility. These variables are not necessarily causative in nature. It is how the variable works upon the youth and how the youth interprets or resolves the variable that can lead to susceptibility.

Etiological factors can be found within the context of developmental success or failure, the nature of relationships, the quality of the environment, the nature of life experiences, the definition of and ability to meet human needs, and the presence or lack of resiliency and protective factors. The presence of a negative, unhealthy, or traumatic factors are not direct causes of etiology, but rather the presence increases susceptibility and risk-potential. Each factor is filtered through the youth's internal and external protective and resilient factors, and the presence or lack of these factors impacts etiology. (See Table A2 for possible etiological issues).

Insert Table A2

Etiological or causation factors begin the chain of events (internal and external) that lead to departure from a normative developmental trajectory. Etiological variables create susceptibilities in youth. These susceptibilities are expressed in the form of vulnerabilities. Gilgun (2006) wrote, "Vulnerabilities represent residual emotional and psychological hurt" (Longo and Prescott, Editor, p. 384). The source of etiological variables are multiple and varied. Once experienced they reside within the individual in the form of a vulnerability.

The etiological variable is a point of demarcation, and notes the beginning of a chain of events or process. It identifies the point of departure from the normative developmental trajectory. There is no normal or expected process once the variable is experienced. Once experienced, the process of departure or pathway is uniquely individualized and defined by each youth, and although the variable may be common or similar the impact on the youth is uniquely different.

The etiological factor leaves the youth susceptible, and creates a state of disequilibrium within the youth. It also acts to lower the threshold of tolerance. It is in this state of vulnerability or disequilibrium the risk potential grows. This state of disequilibrium impacts developmental success, perception of relationships, contextual issues, how the youth is perceived, interpretation and resolvement of experiences, the definition and obtainment of needs, and the development of internal assets, qualities, resiliency and protective factors.

Life is shaped by the context of development, contextual issues, relationships, and experiences. When the youth experiences an etiological variable, every context of the youth's life is impacted. These experiential and contextual issues serve to moderate or exacerbate the impact of the variable upon the youth.

Once experienced and disequilibrium occurs, the youth must find a pathway to resolution. This pathway is intended to escape or ameliorate the impact of the variable. Therefore, a pathway to resolution is selected. This pathway is implemented in a hope to restore health, happiness, and homeostasis in the youth's life. Pathways to resolution can either be healthy or unhealthy. It is believed that a pathway to acting out can serve as a resolution of the problem (in a temporary and unhealthy way). However, because the pathway to resolution does not necessarily fix the vulnerability, once homeostasis is reestablished the vulnerability lies dormant within the youth waiting to be triggered again. This makes the youth more susceptible to life's

issues and challenges, and increases potential for acting out. As the youth advances through development, the etiological source of the problem may not be remembered. However, the susceptibility lies within, having been accommodated into the youth's internal working model, coping, and need-attainment skills.

It is through this process that acting out occurs. It is through understanding the process that clinicians recognize the youth's etiological factors and pathway to offending. Treatment results from the identification of etiological factors. Treatment should be individualized to address and ameliorate the etiological and maintenance factors allowing the youth to be restored to a healthy and normative developmental trajectory.

Appendix Three: Communication Points and Possible Parallel Treatment Assignments

Clarification:

1. Provision of Information

   Offender Assignments

   a. Status: The offender communicates the results of the legal disposition, where he or she has been placed (living status), treatment location, including name and phone number of the therapist.
   b. Treatment: The offender communicates the expectations of treatment including specific treatment goals, success expectations, and potential timeframes for completion, reintegration (if applicable), reunification, and discharge.

   Victim and Caregiver Assignments

   c. The victim, caregiver, or other family members may choose to share treatment information including location, treatment goals, issues, struggles, and success expectations.

2. Acknowledgment of Abuse Occurrence

   Offender Assignment

   a. The offender acknowledges that the abuse occurred, and may include a description of the abuse details. (For professional use only as this may be too sensitive to share with the victim or caregiver.)

   Victim and/or Caregiver Assignments

   b. Victim acknowledges the offender's communication and is able to clarify to the therapist an assurance that the abuse occurred.
   c. The caregiver communicates to the victim a knowledge that the abuse occurred.
   d. The victim communicates to his/her therapist the details of the abuse.

   Professional Assignment

   e. Compares the offender and victim stories and identifies discrepancies.

   Offender Assignment

   f. The discrepancies in the story are processed with the offender, and offender is given the opportunity to respond to the discrepancies.

3. Realignment and Clarification of Responsibility

   Offender Assignment

   a. Offender prepares a communication accepting total responsibility for the abuse, which includes a statement that the victim or caregiver are not responsible for the choice to offend.

Victim and Caregiver Assignments

b. Victim receives and reviews the offender's responsibility statement, acknowledges the offender's responsibility for the abuse, and works to eliminate any responsibility misattributions. Victim confronts responsibility misattributions and disowns responsibility for the abuse.
c. Caregiver(s) receive the offender's responsibility communication, acknowledges the offender's responsibility and victim's non-accountability, and works to eliminate any responsibility misattributions and disowns any responsibility for the abuse.
d. Caregiver(s) communicate with the victim that the victim is not accountable and does not share blame for the offense.
e. Victim and/or caregiver(s) can then elect to communicate with the offender that they acknowledge that the offender is totally responsible for the choice to offend.
f. Caregiver, family members, and other important individuals provide a statement to the victim that they do not blame him/her for the abuse.

4. Acknowledgement of Wrongness and Harm Caused

Offender Assignment

a. The offender prepares a general statement acknowledging that the choice to offend was wrong and harmed the victim, caregiver, and others. At this point, the offender may not have good insight into the specific harm caused. The statement however simply clarifies that the offender understands the abuse was wrong and harmed others.

Victim and Caregiver(s) Assignments

b. Victim, caregiver(s), family members, and other important individuals communicate an Abuse Impact Statement to the offender expressing how the abuse impacted and harmed them.
c. The victim, caregiver, family members, and other important individuals communicate to the each other, the professional team, and if appropriate, the offender, an acknowledgement that the abuse was wrong.

Offender Assignment

d. Offender receives the Abuse Impact Statement and then prepares a communication that acknowledges the harm that each individual experienced as a result of the abuse and how the offender feels about having caused the harm. This is not an apology simply an acknowledgment, referred to as the Individualized Harm Statement.

Victim and Caregiver(s) Assignment

e. Victim and caregiver(s) receive the Individualized Harm Statement from the offender.
f. If desired the victim, caregiver(s), or others may comment or provide feedback to the offender regarding the statement.

5. Clarification of Abuse Questions and Dynamics

Offender Assignments

a. Offender lists and defines the abuse dynamics that includes a description of the etiological factors that influenced or led to the choice to offend sexually, the pathway to offending, and the process of how the choice to sexually offend was made. It should include any factors that allowed or maintained the abuse, and any factors that could trigger a re-offense.
b. The offender communicates the abuse dynamics with the caregiver through a clinically facilitated manner. The information can be communicated to the victim, only if the victim's therapist or clinical advocate believes it will aid in his/her healing.

Victim and Caregiver(s) Assignment

c. Receives the abuse-dynamics communication from the offender, and processes it with clinical advocate.
d. Prepares and communicates any questions needing clarification.
e. Prepares and communicates a list of issues that must be resolved for the abuse to end, healing to occur, and reunification to be successful.

Offender Assignments

f. Receives clarification questions from victim and/or caregiver and works to prepare a response that will be shared in the Resolution Phase.
g. Receives the list of issues needing to be resolved, clinically processes the list, and adds any issues that have been overlooked.

6. Addressing Restitution and Amends

Offender Assignment

a. Offender communicates the desire to make amends for the choice to offend.

Victim and Caregiver(s) Assignment

b. Communicates personal expectations and desires regarding restitution and amends.

Offender Assignment

c. Develops and communicates his or her plan to make amends through addressing the restitution and reparation needs.

Victim and Caregiver(s) Assignment

d. Receives and accepts plan or sends it back for improvement. This process continues until plan is developed.

7. Assessment and clarification of unhealthy family dynamics and issues

Offender Assignment

a. The offender identifies and verbalizes any negative or unhealthy family dynamics and issues. These may have been previously identified in the family assessment. If necessary, the therapist can aid the offender in creation of a list of issues.
b. The offender states the impression of the identified issues, including his or her effect on the issues, whether the issues influenced etiology of the offending, and how those issues keeps the family from healthy functioning.
c. The offender prepares a communication stating understanding and perception of unhealthy and family dynamics and issues.

Victim and/or Caregiver Assignment

d. The victim and caregiver(s) receive and review the offender's communication.
e. The victim and caregiver(s) identify and list all unhealthy and/or negative family dynamics and issues, their perception of the issues, their responsibility for the dynamic, and how it impacts individual and the family functioning.
f. The victim and caregiver may forward this assignment to the offender for review.

Offender, Victim and Caregiver Assignment

g. After formulating their list, participants will then identify the issues and dynamics they feel need to be addressed in the Resolution Phase.

Professionals Assignment

h. Therapists or clinical advocates gather all lists and in conjunction with the finding of the assessment create a list of issues and dynamics to be addressed in the Resolution Phase.
i. This list is shared with participants including the offender and those harmed.

8. Elimination of Barriers to Healing

Offender Assignment

a. Offender prepares and sends a communication outlining progress in treatment. This should include assignments they are working on, what they have learned through those assignments, the struggles they are having and why they think they are struggling, and how other participants could help them in treatment.

Victim and/or Caregiver(s) Assignment

b. The victim and/or caregiver receive the offender's progress in treatment communications. There are several options that can be utilized based on good clinical decisions.
    i. Prepare a communication outlining what they are working on in treatment.
    ii. Identify how the offender could help them accomplish the treatment task.
    iii. Send a supportive communication to the offender about the offender's treatment struggles.
    iv. Respond to the offender's request for help in treatment.

Offender Assignment

c. Receives and processes the victim's and/or caregiver's request for aid in their treatment struggles. Prepares a communication to offer help in addressing the task.
d. The offender receives communication from the victim or caregiver offering aid in his/her treatment struggles. This is processed clinically.

Resolution and Reconciliation

1. Ongoing Information Sharing

   Offender Assignment
   a. The offender prepares a communication that informs the victim and caregiver of the offender's status in treatment.
      i. Current goals and assignments
      ii. Learning progress
      iii. Treatment challenges
      iv. Potential timeframes for treatment tasks or discharge.

   Victim and Caregiver(s) Assignment
   b. The victim and caregiver receive the offender's communication and, if desired, respond.
   c. The victim and caregiver are allowed the opportunity to communicate regarding individual clinical treatment, including what current goals and assignments, what learning progress, and treatment challenges. This may include a statement of ways the offender may be of help.
   d. The victim and caregiver may also communicate any questions that would allow clarification of the offender's statement of treatment status.

   Offender Assignment
   e. The offender responds to questions the victim and caregiver asked.

2. Resolution of Abuse Dynamics

   Accountability and Confrontation of Offender
   Victim and Caregiver Assignment
   a. The victim and/or caregiver formulate a communication designed to confront the offender if the offender continues to struggle with taking responsibility for the choice to offend. It is based on a communication of their experience, why it was wrong and how it hurt them. It may also include a confrontation of any ongoing dynamics that are harming or impacting the victim or caregiver.

   Offender Assignment
   b. The offender receives the confrontational communication and processes it clinically. The offender then communicates with the victim or caregiver a corrected responsibility statement.

Misattributions of the Victim, Caregiver(s), and Other Participants

Offender and Caregiver Assignment

a. The offender and caregiver clinically prepare and send a communication to the victim that addresses victim misattributions in the event that the victim, caregiver(s), or other participants are having difficulty correcting misattributions. It is meant to be a supportive and encouraging communication, designed to aid the victim (or caregiver) in correcting the false belief. If the misattribution is centered in accountability for the offense, it is important that the offender accepts full responsibility for the choice to offend. It is also important that the caregiver communicates the message that they do not blame the victim.

Victim and/or Caregiver Assignment

b. The victim (or caregiver) receives the communication and is clinically helped to process it and to work to eliminate any misattributions.

Identifying, Addressing, and Resolving Abuse Issues and Dynamics

Offender Assignment

a. The offender identifies his or her pathway to offending with new insight gained in treatment. This includes risk for re-offense etiological, maintenance, and triggering factors. The communication will also address the treatment plan to resolve these factors. The offender can also provide an acknowledgement of the problem and a commitment to change. The communication should address potential red flags for caregivers to watch for that would signal digression into old patterns. The offender can also begin to clarify the plan to live an abuse-free lifestyle.
b. The offender prepares a second communication designed to address abuse issues and dynamics. These issues and dynamics were identified in the Clarification Phase. The offender states perspective on each issue along with a recommendation of addressing or resolving the issue. The offender should reiterate knowledge that the choice to offend harmed others.

Victim and/or Caregiver(s) Assignment

c. The victim and caregiver prepare and send a communication to the offender outlining a personal perspective of how to offense harmed them.
d. The caregiver and, if deemed clinically necessary, the victim, receive the pathway-to-offending communication from the offender. The victim and/or caregiver work to understand the offender’s pathway, risk factors, treatment issues, and intervention plan and ask any clarifying questions.
e. The victim and caregiver receive the offender communication regarding abuse issues/dynamics and compare it to the list formulated in the Clarification Phase. The offender’s perspective and plan to resolve issues is processed by the victim and caregiver, and individual perspective and recommendations to change the issues is communicated. Clarifying questions are asked to help resolve issues.

Offender Assignment

f. The offender receives the offense-impact statements communicating the victim and caregiver's experience and interpretation of the harm caused. The offender then clinically processes this experience and work to develop congruent emotion (remorse and/or regret) for having caused this pain. The offender then begins work on the apology communication.
g. The offender receives the victim and/or caregiver communication regarding the pathway and abuse dynamics, responds to any questions, and asks any clarifying questions. This process continues in a dialogue until the issue is understood or resolved.

3. Emotional Expression

Victim and/or Caregiver Assignment

a. If deemed clinically necessary, the victim and/or caregiver are clinically aided in preparing a communication that expresses individual emotions regarding the abuse and/or the offender.

Offender Assignment

b. The offender receives the emotional-expression communication, is clinically helped to process the emotion, and seeks to find a congruent emotion for having caused this. The offender prepares a communication that empathetically responds to the victim and/or caregiver.

4. Individual Treatment Needs

Offender Assignment

a. The offender prepares and sends a communication outlining individual treatment progress including current tasks and goals, progress, and any treatment struggles. The offender may also ask for support in achieving a treatment goal from the victim or caregiver.
b. The offender prepares a communication offering support to the victim or caregiver in the achievement of individual tasks, and offers help if needed.

Victim or Caregiver Assignment

c. If desired, the victim and/or caregiver send a communication of treatment progress. This can include what they are learning, and current tasks and goals. It may also include any requests for help on a given treatment task or goal.
d. The victim and/or caregiver may send a supportive communication to the offender, expressing support or offering help in the offender's achievement of treatment tasks and goals.

5. Apology

Offender Assignment

a. The offender prepares and communicates a sincere and authentic apology to all they harmed. The authentic apology must include an acceptance of accountability, a statement the victim and caregiver are not responsible, an acknowledgment of wrongness and harm caused, an expression of remorse and regret, a statement addressing treatment and change, a commitment to continued change, and a statement of desired relationship.

Victim and/or Caregiver Assignment

b. The victim and/or caregiver receive and process the apology, and acknowledge through a communication that the apology was received.
c. The victim and/or caregiver may then choose to offer a communication to the offender that could include a statement regarding their perception and feeling about the apology, questions for clarification, acceptance or non-acceptance of the apology, and whether or not forgiveness is offered.

Offender Assignment

d. The offender receives the additional communication, if asked, offender answers any clarifying questions, communicates a response to the victim's and/or caregiver's perception and emotions, acknowledges the acceptance of the apology, and responds to a possible offer of forgiveness.

6. Defining Relationships

Offender Assignment

a. The offender creates and communicates a definition of the desired relationship with the identified participants.

Victim, Caregiver and/or Other Participants Assignment

b. Receive and process offender's desired-relationship communication. Participants analyze if their expectation of the desired relationship matches the offender's. If so, agreement is communicated to the offender. If not a redefinition of the desired relationship is communicated.

Participants Assignment

c. Participants continue the dialogue until the desired relationship is defined and agreed to by all. A plan is then negotiated for how to achieve the defined relationship.

7. Reconciliation of Families

Offender Assignment

a. The offender identifies and communicates a list of familial issues that was prepared in the Clarification Phase, and adds to it if new issues have been identified. The list is then forwarded to other participants. The communication should address:

i. Familial issues that contributed, influenced, or acted as etiological factors in the offender's choice to sexually offend.
ii. Factors that allowed sexual-offending to occur in the family, and familial dynamics that may have allowed, supported, hidden, or maintained the abuse patterns.
iii. Unhealthy family dynamics. (See family assessment section for possible issues.)

Victim, Caregiver and/or Other Participants Assignment

b. Victim, caregiver, and any other participants receive the list, clinically review it, add to it if issues are missing, and approve the list.

Participants Assignment

c. Participants engage in a dialogue designed to address and reconcile the identified issues. The communication should come to a consensus of identified problems, discuss the influence of the issue, discuss accountability, focus on solutions, create a plan of action to address the issue, and work to eliminate or control the issue. Communication should be continued until familial functioning is increased.

Caregiver Assignment

d. Caregiver reviews the roles and functions of caregivers (Addendum 1), identifies issues, deficits, and weaknesses, and clinically prepares a plan to increase functioning.

8. Healing Trauma

Offender Assignment

a. Offender develops and sends a supportive communication to other participants intended to offer encouragement in the progress of the offender's healing. The communication can also offer help, if needed, on any treatment task.

Victim, Caregiver and/or Other Participants Assignment

b. If needed, ask offender for help on a given treatment task
c. If desired send a supportive communication to the offender encouraging his/her treatment and healing.

Reintegration

1. Development and Implementation of a Reintegration Plan

Offender Assignment

a. The offender clinically prepares a reintegration plan that outlines steps in developing outside interests, hobbies, goals and life pursuits, and outlines and demonstrates understanding of developmental competencies, social skills, and clinical gains.
b. The offender creates a plan to practice the above in a less structured environment.

c. The offender clinically develops a safety plan, or contract, for reintegration activities. The safety plan should include:
    1. Rules for contact, both planned and unplanned
    2. Rules and boundaries for supervised visits
    3. Rules, parameters, and expectations for the adult supervisor
    4. An outline of activities with accompanying goals, rules, and timeframes including time of day and length of activity
    5. Rules for face-to-face contact with the victim
    6. A plan for visitation including full spectrum, in clinical office, supervised and unsupervised, in community, and at home, outlining goals, rules, and timeframes.

d. The offender clinically outlines a plan to reintegrate back into the peer group.

e. The offender outlines a plan to provide opportunities for victim, caregiver(s), and other participants to observe changes the offender has made. This includes assisting participants in recognizing what to look for and how to observe the offender.

Victim, Caregiver, and/or Other Participants

f. Receive and clinically review the reintegration plan. Make recommendations or changes to the plan, send plan back to offender.

Steps for the offender

g. Review recommendations and changes in the plan, if appropriate integrate into the plan.

Step for all participants

h. Agree to the plan and implement the tasks.

Reunification

1. Restoration of Relationships

Offender Assignments

a. Clinically develops a plan for reunification that addresses restoration of relationships with the victim(s), caregiver(s), and other participants
    i. Defines the desired relationship
    ii. Outlines correct and healthy definition for the relationship
    iii. Commits to continue to identify, confront, and heal any dynamics or issues that block the creation or restoration of relationships
    iv. Outlines progress made and areas that need to continue to be addressed
    v. Commits to restore or create the love bond that meets clinical and societal norms, and identifies state of current love bond and how to improve it
    vi. Deals with and heals the dynamics and issues of the abuse experience, and identifies issues dealt with, as well as those needing to be healed
    vii. Commits to an emotional connection, and to be sensitive or attuned to the needs, dispositions, perspectives, and emotions of others

viii. Develops an awareness of personal impact upon others
ix. Commits to healthy communication, by identifying and changing negative, demeaning, or abusive communication, while increasing healthy and positive communication patterns. Also commits to communicate feelings and needs, and to respond to other's communication in an empathetically congruent manner
x. Identifies how trust was damaged, acknowledges the current deficits in trust, and outlines the criteria on which trust will be reestablished
xi. Defines the expected role of the relationship including obligations, functions, and tasks associated with that role
xii. Commits to offer love in the relationship by identifying issues and experiences that have affected love, and commits to change and restore love
xiii. Outlines a plan to deal with future issues and problems, and commits to follow the plan
xiv. Commits to let go of the abuse experience and move forward by not allowing the past abuse to impact the desired relationship
xv. Clinically develops a plan for reunification that addresses the creation of a quality, healthy, and safe home environment.
    1. Commits to a safe, loving, and healthy family environment
    2. Writes a commitment statement agreeing to develop a desire to have a healthy family, committing to restore healthy relationships and to interact and contribute to the overall healthy milieu of the home.
    3. Commits to behave and interact in healthy and safe ways
xvi. Clinically develops an ongoing intervention and safety plan
    1. Outlines an intervention and safety plan to be used on an ongoing basis
    2. Outlines the process for continued clarification and resolution of all future issues and problems
    3. Commits to the level of health and functioning the family desires
    4. Outlines potential problems and issues that could occur, and potential risks of re-offense and creates an intervention plan to manage potential risks
    5. Addresses the vulnerability issues of the victim, and creates a plan to address any slippage in the offender's healing or functioning
    6. Outlines a familial plan to address any future issues or problems within the family. This defines a step-by-step problem solving guide.

Victim, Caregiver, and/or Other Participant Assignment

b. Receives and clinically process the reunification plan developed by the offender, accepts or redefines the plan, and sends it back to the offender. It should address all aspects of the previous offender assignments as well as

adding an adjoining plan for the identified dynamics and issues and how to address them, as well as a statement of the desire to restore the love bond with a plan to improve it.

Offender Assignment

c. Receives the adjusted reunification plan and incorporates suggestions and changes made by other participants, then submits the final reunification plan for review by professionals and other participants.

Caregiver(s) Assignment

d. Clinically identifies weakness or deficits in the provision of the expected roles and functions in raising healthy children (see Addendum 1). Develops and implements a plan to improve personal performance.

Professional Assignment

e. Reviews the reunification plan, ensures relationships are being restored in a healthy manner, verifies the home environment is improving and is functioning safer and healthier, and there is an adequate safety and intervention plan in place.

Participants Assignments

f. Engage in a dialogue with all participants until an agreement is reached and a commitment to the reunification plan is made.
g. Agree to reunification.
h. Reunify.
i. Plan for and have a celebration of reunification.

Closure

Offender Assignments

a. Complete the individual treatment requirements for this Phase, including self-forgiveness, then develop a communication that expresses a desire to bring closure to the abuse experience.

Victim, Caregiver(s), and/or Other Participants Assignments

b. Complete individual treatment prerequisites including self-forgiveness, receive and review the offender's communication, then communicate a personal desire to bring closure to the abuse experience.

All Participants Assignments

c. Engage in a dialogue until an agreement can be reached that it is time to let go of the abuse and move forward. This dialogue indicates treatment prerequisites have been met, and resolution, reconciliation, and reunification tasks have been completed.
d. Give a statement of commitment to bring closure to the abuse experience.
e. Create and participate in an activity to celebrate closure of the abuse experience.

f. Close resolution/reunification services.

Table 2-1: Difficult Decisions

The follow are potential issues that need to be resolved:

1. Should the offender be removed from the home?
2. Should the victim be removed from the home?
3. Is reunification necessary?
4. When is reunification contraindicated?
5. When is reunification not safe?
6. When should reunification start?
7. Who should participate?
8. When are participants ready, and what is needed to prepare them?
9. Should reunification take place if the victim is not in treatment?
10. When should reunification be stopped or terminated?
11. When should the offender not be returned home?
12. When should face-to-face contact between the offender and victim occur?
13. When should visitation begin?

Table 3-1: Goals of Clarification

1. Create a safe forum for participants to clarify the abuse and the corresponding issues and dynamics.
2. Aid in healing all participants through the creation of the parallel treatment process
    a. Establish clinically facilitated communication between the offender and those harmed by the abuse
    b. Allow direct clarification of specific abuse issues and dynamics
    c. Facilitate communication that aids in healing for all participants.
3. Clarify the abuse experience and the resulting issues and dynamics through the presentation of prepared materials designed to accomplish or clarify the following specific clinical points
    a. Sharing of critical information
    b. Acknowledgement of abuse occurrence
    c. Realigning and clarifying responsibility
    d. Acknowledgment of wrongness and harm caused.
4. Clarification of abuse questions and dynamics
    a. Addressing restitution and amends
    b. Assessment of family dynamics and issues.
5. Identification and elimination of barriers and issues affecting the healing of those impacted, including the presentation of healing communications through clarification assignments.
6. Achievement of individual treatment goals for each participant.
7. Opening of communication channels between participants but specifically between family members.
8. Processing, reframing, and healing the trauma of the abuse.

Table 3-2: Benefits of Clarification

1. Creates a forum for clinically-facilitated communication between the offender and those impacted.
2. Provides a clinical environment that aids all participants in healing the trauma of the abuse.
3. Empowers those impacted by providing them with a voice, and valuing their opinion, through participation in the resolution/reunification process.
4. Creates clarification tasks that provide participants with needed information regarding the abuse.
5. Aids in realignment of responsibility by holding the offender accountable, and simultaneously aids the victim and caregiver in eliminating their misattributions of responsibility.
6. Aids the offender in recognizing and owning responsibility for the harm caused by the choice to sexually offend.
7. Allows victims to clarify how the abuse impacted and harmed him/her.
8. Helps victims and families to receive an assurance that the abuse occurred, while allowing the offender to clarify abusive behaviors.
9. Provides a forum for victims to have questions answered regarding the abuse.
10. Allows participants to identify the etiology factors and pathway to offending.
11. Identifies negative and unhealthy familial dynamics and issues.
12. Aids in achievement of individual treatment goals and tasks.
13. Facilitates healing in all participants.

Table 3-3: Possible Methods of Communication

Any of the following methods can be used during the clinically-facilitated dialogue to communicate the task or assignment

1. Written messages including letters, assignments, etc.
2. Recorded messages, including audio tape, CD, video recording, etc.
3. Therapist-conveyed message
4. Face-to-face session where the participants meet and communicate the message.

Table 3-4: Commonly Asked Questions of Victims of Sexual Abuse

1. Why did you do it?
2. Why did you pick me?
3. Is it my fault, did I do something wrong to deserve this?
4. Have you abused anyone else?
5. Are you mad at me?
6. Are you sorry?
7. How did you think I would feel?
8. How do you think I feel now?
9. Do you still love me?
10. How do you feel about me?
11. How do you think the abuse has affected my life?
12. How did you just ignore my feelings?
13. Didn't you feel guilty about what you did?
14. Is treatment helping?
15. What do you need to work on in treatment?
16. Will you do it again?

Table 4-1: Goals of the Resolution and Reconciliation Phase

1. Aid participants in defining and resolving abuse issues and dynamics
   a. Heal the trauma of sexual abuse and other individual problems and issues
   b. Restore optimal level of individual functioning.
2. Aid participants in reconciling unhealthy, damaging, and inappropriate issues and dynamics within the family
   a. Eliminate abusive or unhealthy relationships, issues, and dynamics
   b. Restore love, roles, and relationships within the family
   c. Create a quality and healthy family environment
   d. Allow families to prepare for reunification.
3. Provide a forum for the offender and those impacted to discuss the abuse
   a. Establish clinically-facilitated communication
   b. Allow an open discussion of the offense, dynamics, impact, and treatment
   c. Allow expression of feelings
   d. Provide understanding of abuse issues and dynamics
      - Etiology and pathway to offending
      - Triggering factors
      - Factors that allowed the abuse to occur and be maintained
      - Impact of the abuse
   e. Resolve and bring closure to the abuse experience.
4. Create a parallel treatment process that allows clinically-facilitated communication on the following identified tasks
   a. Share information on an ongoing basis
   b. Resolve abuse issues and dynamics
      - Facilitate accountability and confrontation of offender
      - Eliminate misattributions of the victim, caregiver, and/or other participants
      - Identify, address, and resolve abuse issues, dynamics, and questions
   c. Facilitate emotional expression
   d. Achieve individual treatment needs
   e. Facilitate offender apology
   f. Define future relationships
   g. Reconcile family issues and dynamics.

Table 4-2: Benefits of the Resolution and Reconciliation Phase

1. Provides updated information regarding offender treatment, placement, reintegration, and discharge planning.
2. Provides communication to resolve and heal issues and dynamics caused by the sexual offense
    a. Holds the offender accountable
    b. Confronts the offender regarding the choice to sexually offend ensuring acceptance of responsibility, wrongness, and harm caused
    c. Aids those harmed in eliminating abuse misattributions.
3. Provides a forum for healthy emotional expression.
4. Identifies the etiological factors and dynamics that contributed to the choice of offending
    a. Identifies the offender's pathway to offending, treatment needs, and risk factors
    b. Identifies what is needed for the offender to live a healthy abuse-free lifestyle
    c. Provides education to caregivers, support system, and victim(s) of what the offender needs to accomplish in treatment to change his/her life and offense potential.
5. Clarifies individual treatment goals of participants
    a. Aids in the accomplishment of individual treatment needs
    b. Reviews the progress made on individual treatment goals.
6. Provides a forum for apology, possible forgiveness, and closure of the abuse.
7. Creates a forum to define and heal relationships
    a. Resolves barriers and dynamics that are preventing healthy relationships
    b. Heals relationships
    c. Works to restore the desired relationship.
8. Reconciles issues within families
    a. Identifies family issues and dynamics that were etiological factors in the choice to offend
    b. Identifies, addresses, and resolves unhealthy family dynamics
    c. Increases caregiver relationships, qualities, roles, and functions.
9. Creates a forum for clinically-facilitated communication that encourages healing of all participants.
10. Restores participants to optimal health and functioning.

Table 5-1: Goals of Reintegration

1. Reacclimatize offenders to a non-supervised and less-structured environment.
2. Allow the offender to use skills learned in treatment in a non-supervised and less-structured environment.
3. Assist the offender in establishing an ongoing support network.
4. Allow those harmed and impacted, specifically the victim, caregiver, and family to observe changes the offender has made through treatment.
5. Reintegrate the offender back into the family, support system, peer group, and community
    a. Develop and implement a reintegration plan
    b. Help offender identify and develop outside interests, hobbies, goals, and life pursuits
    c. Assist in the development of competencies and social skills, and provide opportunities to practice those skills
    d. Observe the changes in the youthful sexual offender.

Table 5-2: Developmental Competencies Defined

Emotional competency is defined as:

The ability to achieve regulation of individual emotions

a. Recognizing, and assigning meaning to both emotion and triggering experiences
b. Having healthy perspectives and skills to deal with social messages and responses
c. Having a healthy emotional perspective
d. Expressing emotions in a healthy way
e. Regulating emotions
f. Adjusting emotional presentation
g. Feeling and expressing joy and pleasure
h. Establishing emotional self-mastery.

The ability to empathetically respond

a. Establishing emotional individualization
b. Attuning emotionally with others
c. Possessing a healthy perspective of others emotions
d. Recognizing one's impact on others
e. Eliciting individual emotional response when impact upon others is detected
f. Connecting to another's emotional state
g. Responding empathetically.

The ability to establish and maintain emotional connection

a. Desiring and valuing emotional connection with others
b. Developing the skills to emotionally connect
c. Establishing and maintaining emotional connection.

Social competency is defined as:

Learning to act as a social being

a. Establishing autonomy
b. Learning to enjoy interacting and relating with others
c. Learning the rules for becoming and performing as a social being
d. Identifying roles within social settings
e. Developing healthy social skills
f. Developing social mastery; being able to act appropriately and proficiently in any social setting.

Establishing social relatedness

a. Establishing the skills to socially relate and connect
b. Establishing relationships
c. Establishing intimacy.

Cognitive competency is defined as the ability to form a healthy cognitive structure

a. Receiving information in a healthy way
b. Interpreting information correctly
c. Forming healthy mental maps

d. Categorizing beliefs in a correct and healthy manner
e. Forming an accurate and healthy value system
f. Forming a correct and healthy moral code
g. Learning to operate as a moral agent based on correct principles
h. Creating the skills to refine cognitive structure when the need arises
i. Reestablishing cognitive equilibrium after refining one's cognitive structure
j. Creating a positive, correct, healthy, hopeful, and optimistic paradigm for life
k. Developing the capacity for metacognition or mentalization.

Sexual competency is the ability to become a healthy sexual being

Maturing, unfolding, and developing sexuality

a. Understanding the nature of one's body
b. Understanding body sensations and functions
c. Learning correct terminology for body parts, feelings, and functions
d. Successfully dealing with external sexual messages, responses, and feedback
e. Learning the boundaries, rules, and expectations of sexuality
f. Being aware of the consequences for sexual behavior
g. Understanding and incorporating secondary sexual characteristics into identity
h. Gaining and incorporating correct and healthy sexual information and knowledge
i. Creating skills to make correct healthy sexual decisions
j. Creating healthy sexual values
k. Establishing personal rules for expression of sexuality
l. Establishing a healthy sexual arousal profile
m. Successfully answering sexuality questions
n. Developing values and skills to control sexuality
o. Establishing personal responsibility and accountability for one's sexuality
p. Understanding and establishing healthy sexual motives and desires
q. Creating a healthy sexual identity.

Learning to incorporate and function as a sexual being in a social context

a. Developing curiosity about others' bodies and sexuality
b. Learning to interact with others in a sexual way (playful and exploratory)
c. Learning to converse about sexuality in a social setting
d. Defining and incorporating one's sexuality within a social context
e. Developing sexual attraction to others
f. Developing the desire to pair bond
g. Learning healthy skills for dating and courting
h. Developing the skills to establish relationships within a sexual context
i. Creating the ability to distinguish individual needs from others' needs
j. Learning to express sexuality and sexual behavior in a correct and healthy way
k. Developing the skills to establish and express intimacy through sexuality.

Spiritual competency is defined as developing the essence of being human, by establishing ones worth, value, and meaning and purpose of life and how one fits in relation to other and a potential bigger picture:

A. Establishing autonomy based on the development of healthy internal qualities and traits
    i. Empowerment
    ii. Self motivation
    iii. Creativity and adaptability
    iv. Capacity to learn
    v. Integrity
    vi. Ability to commit
    vii. Positive attitude
    viii. Expectation of hope
    ix. Honesty
    x. Internal locus of control
    xi. Positive pro-social identity
    xii. Positive self esteem
    xiii. Self-regulation.
B. Identifying interest, beliefs, tenets, values, and goals that define meaning and purpose of life.
C. Creating an individual belief paradigm that defines life, truth, and provides moral meaning.
D. Creating connections, on a spiritual level, with others, the world, and, if desired, a deity.
E. Defining one's soul, providing direction in guiding life in a spiritual manner.

Table 5-3: Social Skills

1. Interpersonal skills
    - Recognizing the rules and expectations for relationships
    - Establishing and maintaining healthy relationships in a positive manner
    - Creating intimacy and trust
    - Learning to enjoy relationships with others
    - Establishing and enjoying healthy social interaction
    - Relating socially to others
    - Handling joint decisions and interpersonal conflict
    - Acquiring conflict-resolution and negotiation skills
    - Possessing the ability to compromise
    - Asking for help from others
    - Accepting and giving compliments
    - Expressing empathy
    - Taking perspective
    - Establishing emotional connections with others
    - Responding empathetically to others
    - Understanding the rules for social interaction
    - Displaying appropriate manners and positive social presentation
    - Following instruction
    - Accepting a "no" response
    - Functioning as a group member with positive group participation
    - Establishing healthy communication skills
    - Expressing self
    - Listening to others
    - Possessing positive conversational skills.

2. Intrapersonal skills
    - Possessing the ability to enjoy life, celebrate good things, feel pleasure and joy
    - Having an expectation of hope and optimism
    - Developing self-regulation skills, emotions, thoughts, and behaviors
    - Delaying gratification
    - Possessing impulse deferment
    - Choosing positive rather than negative behaviors
    - Governing self, being self-disciplined
    - Tolerating frustration, unfavorable events, emotional distress, and problems
    - Managing criticism or rejection
    - Possessing internal locus of control
    - Developing healthy sexual functioning
    - Possessing healthy values and moral code
    - Possessing integrity and honesty
    - Developing the ability to commit
    - Developing positive internal qualities

- Possessing assertiveness, empowerment, and self motivation
- Developing creativity and adaptability
- Developing the capacity to learn
- Possessing positive prosocial attitudes, identity, and behaviors
- Having a positive self-esteem
- Fostering healthy internal perspectives
- Having a healthy cognitive structure
- Establishing independence, autonomy, and agency
- Increasing accountability and responsibility for actions
- Establishing a sense of control, efficacy, and confidence
- Recognizing that there are opportunities and choices in life
- Seeing a healthy sense of direction and purpose for life
- Maintaining flexibility and patience
- Practicing relaxation or self-soothing skills.

3. Achievement skills
    - Developing healthy coping strategies
    - Developing a healthy work ethic
    - Solving problems effectively
    - Making healthy decisions
    - Setting healthy goals
    - Achieving goals
    - Maintaining healthy need-attainment strategies
    - Learning and applying stress management and leisure management.

Table 6-1: Foundational Criteria for Successful Reunification

Successful reunification should only be attempted once specific foundational tasks have been completed.

Clarification

Prior to reunification of families the following clarification steps must be achieved:

1. Offender clarification steps
    a. Acknowledge that the abuse occurred
    b. Accept 100% responsibility for perpetrating the abuse
    c. Acknowledge that the abuse was wrong and that it caused harm to others.
2. The victim, caregiver, and others impacted clarification steps
    a. Identify and eliminate any abuse-misattributions of responsibility
    b. Recognize that the offender is fully responsible for the abuse.
3. All participants must also identify specific questions regarding the abuse issues and dynamics.
4. Participants and professionals must assess all unhealthy, abusive, or inappropriate family dynamics and issues.

Resolution and Reconciliation

The following tasks must be completed in the Resolution and Reconciliation Phase prior to reunification:

1. All identified abuse issues and dynamics must be successfully resolved to the expectation of participants and professionals.
2. Each participant must clinically express individual emotions regarding the abuse in a healthy and developmentally-appropriate manner.
3. Each participant must achieve the identified individual treatment goals, and must establish stability, self-regulation, and control of life.
4. The offender must offer a sincere apology to all individuals impacted, and participants who receive the apology must make a decision regarding forgiveness.
5. The desired relationships should be identified and agreed upon by all participants.
6. Unhealthy, negative, abusive, and inappropriate family issues should be identified and reconciled to the expectation of participants and professional team.
7. Victims have worked to heal the trauma of the abuse, should feel empowered, and have eliminated or significantly reduced abuse symptomatology.

Reintegration

1. A healthy and safe reintegration plan needs to be developed and agreed upon by all professionals and participants.
2. Participants should be given the opportunity to obverse changes in the youthful sexual offender.

Reunification

1. Safety issues must be assessed and an appropriate safety plan is in place.
2. Participants should work to restore the desired relationships.
3. A quality, healthy, and safe home environment must be established

a. All individual family members must commit to do his/her part in creating a healthy family milieu
b. Caregivers must provide the needed roles and functions within the home
c. The family should develop an intervention plan to address future issues
d. The professional assessment of the family must indicate the family is stable and functioning in a healthy manner.

Table 6-2: Goals of Reunification

1. Reunification of youthful sexual offenders, victims and families who have been torn apart or harmed by the experience of sexual abuse.
2. Establish a gradual, healthy, well-supervised, and clinical process to reunify those impacted by abuse.
3. Systematically restore relationships leading to reconciliation, rejoining, and reuniting of families.
4. Establish a step-by-step procedure with achievable goals and tasks to aid individuals in completing reunification .
5. Create a quality, healthy, and safe home environment.

Table 7-1: Goals of the Letting Go and Closure Phase

1. Aid participants in gaining closure of the abuse experience
    a. Help participants no longer view or define themselves, their life, and others though the abuse experience
    b. Establish healthy criteria for perceptions of self, life, others, and the world
    c. Assist participants in severing the tether of the abuse and move forward with hope and optimism for their life.
2. Bring closure to the abuse experience.
3. Teach self-forgiveness and the process of letting go and moving forward.

Table 7-2: Steps to Forgiveness

1. **Recognition of wrong done**
   The offender will recognize the choice to offend as wrong and that it harmed others. It may also include an understanding of how the choice impacted the offender him/herself. The victim recognizes how the abuse was harmful and impacted his/her life. Caregivers recognize the impact it had on the family and on them personally.
2. **Ownership of responsibility**
   The offender acknowledges responsibility for commission of the offense. The victim confirms that the offender chose to offend. Victims will clearly state that nothing they did caused the abuse. Caregivers will also acknowledge offender responsibility for the offense. The family may discuss factors that led to the offense and its maintenance and how these factors have been changed.
3. **Embracing the emotional impact**
   Participants will define individual emotions regarding being a victim, offender, or caregiver of a victim or offender. Focus will be on how the abuse made them feel. These emotions should have been processed in the Resolution Phase. Each participant will then talk about how feelings have changed since participation or completion of individual treatment, and review current feelings regarding the abuse. Victims will discuss feelings about the offender and caregiver. Offender will define their emotions regarding the victim and the caregiver. Caregiver(s) will talk about their emotions regarding their children.
4. **Acknowledging change**
   Each participant outlines what they have accomplished in treatment or Resolution/Reunification Services to heal the impact the abuse had on their life.
5. **Commitment to the change and move forward**
   Participants outline the individual life plans that were created in the previous step and specify commitments to live a healthy abuse-free lifestyle. Participants may also indicate how the family can help them achieve their life plan. Families review the family plan that was created in the Reunification Phase.
6. **Declaration of self-forgiveness**
   Each participant defines a formal declaration of self-forgiveness which embraces a new commitment to life, and the ability to view self separate from the abuse. It includes a commitment to let go of the abuse and live for today and the future, not anchored to the abuse of the past. This statement of forgiveness should also include a declaration of individual dignity and right to be healthy, happy, and successful in life.
7. **Celebration of forgiveness**
   A formal or informal celebration as an individual or family should occur to recognize forgiveness of self.

Table 8-1: Potential Professional Treatment Goals for Victims

1. Assist victim in making a full disclosure of the abuse.
2. Help victim receive validation that the abuse occurred.
3. Help victim recognize wrongs done on both an intellectual and affective level.
4. Eliminate victim abuse misattributions.
    a. Victim must clearly recognize that the offender was fully responsible for the abuse.
    b. Victim must understand that he/she did nothing to cause the abuse.
    c. Clarify and eliminate victim thinking errors caused by the abuse.
    d. Assist victim in gaining an accurate cognitive perception of self, offender, and the abuse.
5. Help victim reframe and process the abuse experience in an accurate and healthy manner.
6. Assist victim in clarifying emotions about the abuse, self, family, and the offender.
7. Assist victim in embracing and sharing emotion as part of treatment.
8. Identify and heal the abuse issues and dynamics.
9. Identify and heal unhealthy issues and dynamics within the family.
    a. Help victim internalize that caregiver and family acknowledge the abuse, and that the offender is responsible for causing it.
    b. Show victim familial patterns that supported initiation and maintenance of abuse patterns.
    c. Increase caregiver and familial support.
    d. Increase caregiver's commitment to providing a safe and healthy family environment.
    e. Restore healthy familial relationships.
10. Heal the impact the abuse had upon victim.
    a. Guide victim in understanding how the abuse impacted him/her.
    b. Eliminate trauma symptoms.
    c. Heal the impact of the abuse in the victim's life.
11. Assist victim in identifying and healing, or managing co-morbid mental health issues.
12. Empower victim to become a survivor.
    a. Empower victim to be in control of his/her life through establishment of autonomy.
    b. Guide victim in the development of self-protection skills so that he/she feels safe and capable of protecting self.
13. Develop a desire and willingness within the victim to let go of the abuse experience.
14. Help victim reenter a normative developmental trajectory.
15. Guide victim in the accomplishment of developmental competencies.
    a. Social
    b. Emotional
    c. Cognitive
    d. Sexual
    e. Spiritual
16. Guide victim in the development of healthy social skills.
    a. Interpersonal
    b. Intrapersonal

    c. Achievement

17. Help victim to reach optimal level of functioning.
    a. Victim must develop a healthy perception of self.
    b. Victim must view self as worthwhile, competent, and capable.
    c. Victim must have the ability to feel and express happiness and joy.
    d. Victim must function as a healthy individual.
18. Guide victim in developing a healthy support system.
19. Guide victim in developing healthy interests, hobbies, life pursuits, and goals.
20. Help develop a healthy life plan for the victim.
21. Guide victim in making decisions regarding forgiveness of, as well as relationship with the offender.
22. Gain closure of the abuse experience for victim.

Table 8-2: Potential Treatment Goals for Offenders

1. Make a full disclosure of all abusive acts.
2. Accept responsibility for the choice and act of sexually offending, by recognizing and eliminating thinking errors that were used to rationalize, justify, or minimize offending behavior.
3. Accept that the choice to sexually offend was wrong.
4. Acknowledge that the sexual-offending behaviors harmed others, Gain a cognitive and emotional understanding of how the abuse harmed others.
5. Identify abuse issues and dynamics.
    a. Identify etiological factors and pathway to offending.
    b. Identify factors that triggered, allowed or maintained the abuse.
    c. Identify the impact of the abuse upon others.
    d. Recognize he/she has a problem.
6. Recognize unhealthy behavioral patterns, relationship styles, emotional expression, and achievement skills.
7. Identify personal victimization issues, and healing trauma.
8. Develop a desire and commitment to change.
    a. Accept the need to change and empower self to change.
    b. Develop individual commitment to change.
9. With the aid of professional, develop a healthy intervention plan to address unhealthy behavioral patterns.
10. Develop self-regulation skills.
    a. Emotional stabilization
    b. Behavior stabilization
    c. Control of impulsivity and energy
    d. Rule-following and expectation compliance
    e. Negative behavioral patterns management of disrupting and intervening in unhealthy ways
11. Achieve developmental competencies.
    a. Emotional
    b. Social
    c. Cognitive
    d. Sexual
    e. Spiritual
12. Develop healthy social skills.
    a. Interpersonal
    b. Intrapersonal
    c. Achievement
13. Develop the ability to communicate with others in an open healthy manner.
14. Improve mental health with resolution of co-morbid mental health conditions.
15. With support of professionals and participants, practice new skills.
16. Improve offender portion of family functioning.
17. Develop empathy.
    a. Develop victim-specific empathy
    b. Develop general empathy

    c. Be able to respond empathically
18. Offer a sincere apology for sexually-offending to all victims.
19. Improve self-esteem and personal identity, and increase self-confidence, competence, self-mastery, and self-efficacy.
20. Develop healthy sexuality
    a. Eliminate any unhealthy sexual attractions, values, thoughts, and behaviors
    b. Create healthy sexual values, attractions, thoughts, relationships, and behaviors
21. Reintegrate successfully into family, peer group, and community.
    a. Identify and implement outside interests, hobbies, goals, and life pursuits
    b. Establish and practice developmental competencies, treatment gains, and social skills
    c. Establish a healthy peer and support group
    d. Reintegrate into the family and community
22. Reunify successfully with the victim and family.
    a. Restore healthy familial relationships.
    b. Establish healthy role and functioning within the family.
23. Develop intervention and life plans.
    a. Develop re-offense prevention.
    b. Learn goal setting and planning.
    c. Develop hobbies, interests, and life pursuits.
24. Complete self-forgiveness process.
25. Gain closure of the abuse experience. Live for today and the future, not for the past.

Table 8-3: Potential Treatment Goals for Secondary Victims

1. Receive assurance and validation that the abuse occurred
2. Acknowledge that the abuse occurred without minimization, denial, rationalization, or justification.
3. Recognize wrongs done to the primary victim(s) and him/herself on both an intellectual and affective level.
4. Identify, clarify, and eliminate any abuse misattributions of responsibility.
    a. Clearly recognize that the offender was fully responsible for the abuse.
    b. Recognize that they did nothing to cause the abuse.
    c. Recognition that the victim is not responsible for the abuse.
    d. Clarify and eliminate thinking errors caused by the abuse
    e. Gain an accurate cognitive perception of self, victim, offender, and the abuse.
5. Reframe and process the abuse experience in an accurate and healthy manner.
6. Identify and clarify emotions about the abuse, self, victim(s), family, and offender.
7. Expressed and embrace emotions.
8. Share these emotions as part of treatment.
9. Recognize and work to heal the abuse issues and dynamics.
    a. Know the offender's etiology and pathway to offending.
    b. Recognize the triggers and maintenance factors of the abuse.
    c. Recognize how he/she may have influenced the etiological factor.
    d. Understand the offender's intervention plan and how he/she can support and/or supervise these plans.
10. Identify and heal unhealthy issues and dynamics within the family (if caregiver).
    a. Change familial patterns that supported initiation and maintained abuse patterns.
    b. Increase caregiver and familial support.
    c. Increase commitment to provide a safe and healthy family environment.
    d. Restore healthy familial relationships.
    e. Commit to function in the family as a positive member.
11. Heal the impact the abuse had upon him/her.
    a. Understand how the abuse impacted him/her.
    b. Eliminate trauma symptomatology.
    c. Heal the impact of the abuse in his/her life.
12. Identify and heal/manage co-morbid mental health issues.
13. Empower self to become a survivor.
    a. Empower self to be in control of personal life, and establish autonomy.
    b. Develop self protection skills, and feels safe and capable of protecting self.
14. Develop a desire and willingness to gain closure of the abuse experience.
15. Reenter a normative developmental trajectory or role.
16. Accomplish developmental competencies
    a. Social
    b. Emotional
    c. Cognitive
    d. Sexual
    e. Spiritual
17. Develop healthy social skills

    a. Interpersonal
    b. Intrapersonal
    c. Achievement
18. Reach optimal level of functioning.
    a. Develop a healthy perception of self.
    b. View self as worthwhile, competent, and capable.
    c. Feel and express happiness and joy.
    d. Function as a healthy person.
19. Develop a healthy support system.
20. Develop healthy interests, hobbies, and life pursuits and goals.
21. Developed a healthy life plan.
22. Make decisions regarding relationship with offender, victim, and family.
23. Make decisions regarding forgiveness of offender.
24. Bring closure to the abuse experience.

Table 8-4: Treatment Goals for Caregivers in Providing Care

1. Accept presence, authority, and need for professional involvement in their personal as well as their youth's life.
2. Support professional(s).
3. Work collaboratively with the professional(s) including therapist, supervision agents, and court representatives.
4. Show a willingness to comply with rules and restrictions of the court, supervision, and clinical systems.
5. Support and be engaged in the resolution/reunification process.
6. Support and cooperate with all clinical assessments and interventions whether personal or for the youth.*
    a. Support the referring of the youth to treatment.
    b. Support the therapist.
    c. Support the youth's clinical treatment.
    d. Aid youth in achievement of treatment goals.
7. Cooperative and collaborative in safety planning for him/herself and the youth.
8. Become aware of resolution/reunification options, goals, benefits, risks, and phases, tasks, and make an informed decision for youth's participation.
9. Cooperate in preparing himself/herself as well as the youth for participation, and be fully supportive of participation.
10. Work to accomplish the following treatment goals and tasks:
    a. Cooperate in the provision of treatment information.
    b. Acknowledge that the abuse occurred.
        i. Receive and confirm details of the abuse, if appropriate.
        ii. Recognize the potential of reoccurrence of the abuse.
        iii. Accept that the offender has issues and problems that need to be addressed in treatment.
        iv. Accept that the abuse impacted the victim and that clinical help is needed.
    c. Hold the offender fully accountable for the abuse.
        i. Acknowledge that the victim is not responsible in any way.
        ii. Acknowledge that he/she as caregiver is not responsible for the abuse.
        iii. Eliminates all thinking errors of denial, minimization, rationalization, and justification for the offender's choice to abuse others.
        iv. Remove any collusion with the offender.
    d. Acknowledge and define why the abuse was wrong.
    e. Acknowledge that the abuse harmed others, and recognize the impact it had on him/her, the victim, and the family.
    f. Participate in the identification and resolution of the abuse issues and dynamics
        i. Recognize the offender's etiological factors and pathway to offending
        ii. Recognize any triggering and maintenance factors, including those within the family as well as his/her own behavior and interactions with the offender.
    g. Participate in the identification of unhealthy familial issues and dynamics.
    h. Support and aid the victim in healing.
        i. Give assurance that the abuse occurred.

ii. Help eliminate misattributions of responsibility.
iii. Help victim recognize how the abuse was wrong, and that it had impact upon the victim.
iv. Help victim reframe the abuse experience in an accurate manner.
v. Helps victim identify and express emotions in a positive and healthy way.
vi. Help victim identify and heal the impact of the abuse.
vii. Help empower the victim to be a survivor rather than a victim.
viii. Aid victim in reentering a normative developmental trajectory.
ix. Help victim achieve developmental competencies and social skills.
x. Aid victim in achieving the optimal level of functioning.
xi. Help victim restore healthy relationship, roles, and functions within the family.
xii. Help victim develop a healthy life plan.
xiii. Help victim make decisions about a relationship with the offender, and whether to forgive the offender.
xiv. Aid victim in bringing closure to the abuse experience.

i. Support and aid the offender in healing.
   i. Encourage offender to make a full disclosure of the abuse.
   ii. Encourage offender to assume full responsibility for the choice to sexually offend.
   iii. Assist the offender to understanding why the abuse was wrong and how it harmed others.
   iv. Help offender identify etiological factors and the pathway to offending, as well as understand triggering and maintenance factors.
   v. Help offender identify all unhealthy behavioral patterns, relationship and communication styles, need-attainment strategies, values, emotional expressions, developmental failures, and social and achievement skills.
   vi. Assist offender in making a commitment to change.
   vii. Help offender develop self-regulation skills.
   viii. Help offender achieve developmental competencies.
   ix. Help offender develop healthy social skills
   x. Help improve offender’s ability to eliminate or manage mental health issues.
   xi. Assist offender in developing empathy.
   xii. Assist offender in practicing newly acquired skills.
   xiii. Help offender improve self-esteem and worth.
   xiv. Help offender understand healthy sexuality.
   xv. Help guide offender in developing and implementing healthy interventions and life plans.
   xvi. Encourage offender to forgive self.
   xvii. Encourage offender in the closure of the abuse experience.

11. Reconcile issues within the family.
    a. Cooperate in the assessment of unhealthy and negative familial issues, by accepting the findings of the assessment, and agreeing to eliminate or ameliorate these issues.
    b. Provide the needed functions and role within the home.

        i. Provide safe, structured, and quality home environment, protecting the victim and other children from reoccurrence of the abuse, and acting as a protective factor for other harmful events or experiences.
        ii. Provide quality, positive, attuned, and secure relationships for each youth.
        iii. Provide and model healthy standards, principles, values, expectations, morals, and cognitive blueprint.
        iv. Establish, monitor, and enforcing healthy boundaries, norms, and rules.
        v. Provide healthy parenting patterns in teaching and holding youth accountable.
        vi. Provide feedback and consequences to the youth's behavioral and emotional expressions.
        vii. Teach and provide knowledge regarding expectations, standards, norms, mores, skills, and life tasks.
        viii. Provide and allow the youth to grow, mature, and practice developmental competencies and achievement skills.
        ix. Support, guide, and nurture the youth's development and growth.

    c. Provide additional required functions.
        i. Prepare the youth to be a successful adult.
        ii. Provide a healthy stage upon which the child can develop and grow.
        iii. Create a healthy learning environment.
        iv. Ensure the youth gains knowledge, information, and competencies needed.
        v. Instruct and guide the youth's obtainment of developmental competencies.
        vi. Aid the youth in recognizing susceptibilities and vulnerabilities.
        vii. Guide and aid the youth in developing the knowledge and skill needed to succeed as an adult.
        viii. Become or provide healthy role model.
        ix. Provide supervision, feedback, and consequences.
        x. Provide a healthy milieu for experience.
        xi. Provide a healthy milieu to practice developmental competencies.
        xii. Provide a milieu to meet human needs.
        xiii. Instill resiliency.

12. Be capable and committed to take immediate action when safety issues and concerns arise.
    a. Capable of understanding and recognizing risk-issues and patterns in the offender.
    b. Understand and supervise the offender's intervention plan.
    c. Report and confront problems.
13. Establish and supervise healthy and open communication in the family.
14. Support the reintegration of the offender back into the family, peer group, and community.
    a. Participate in the development of a reintegration plan.
    b. Offer the offender the opportunity to practice therapeutic gains, developmental competencies, and new social skills in the community.
    c. Provide quality supervision of reintegration activities.
15. Work to restore relationships within the family.
    a. Create relationships with the offender, victim, and other family members.

    b. Support and guide the restoration of relationships between the offender, victim, and other family members.

16. Develop an ongoing intervention and safety plan for the family.
17. Support healthy reunification of the family.

*The youth refers to the victim, the offender, or other children in his/her care.

Table A1: The Causation Chain

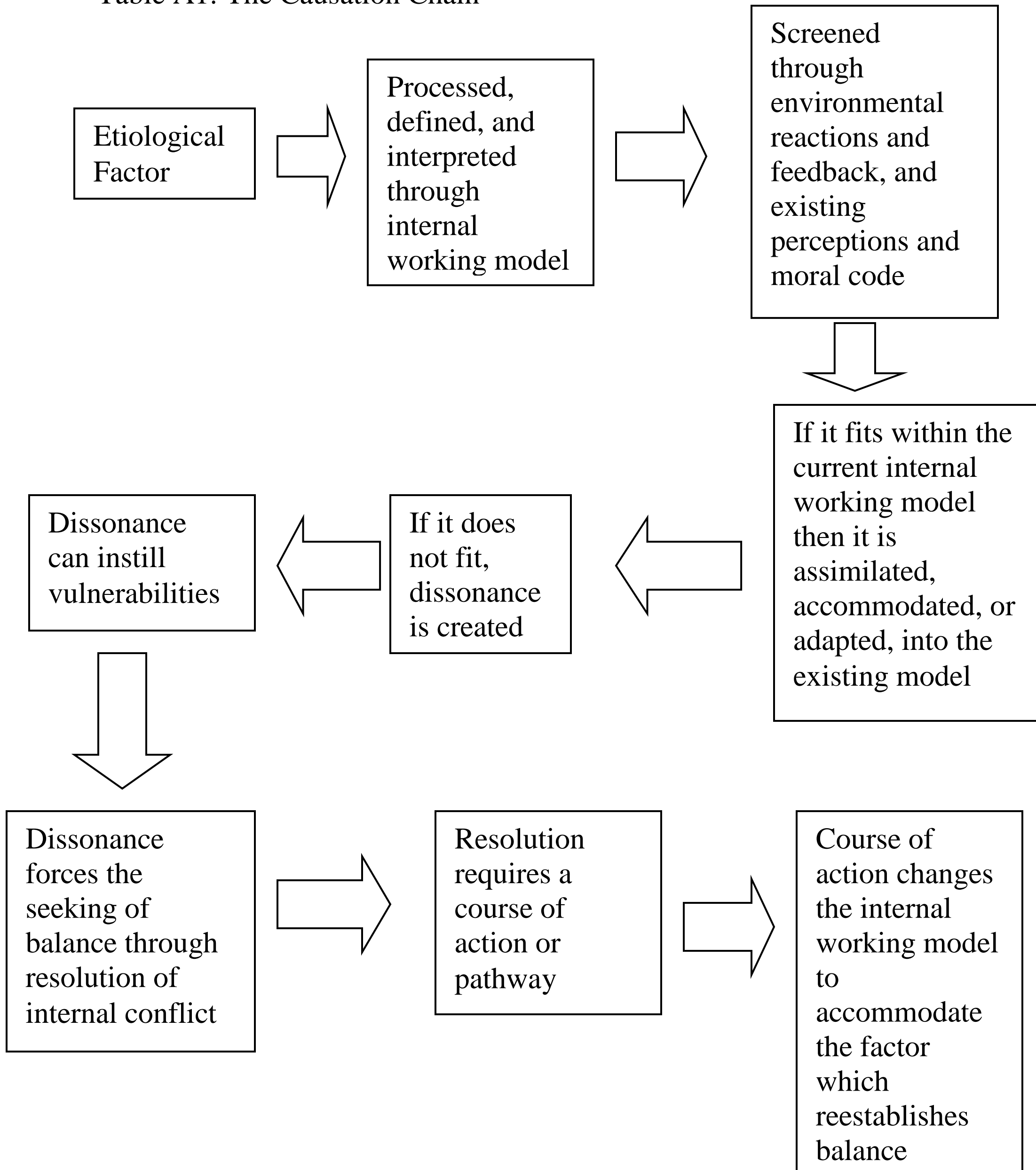

Table A2: Possible Etiological Factors

Etiology of acting out can lie within the following issues.

1. Human development including developmental failure, or failure to achieve developmental tasks and competencies.
2. Contextual issues of environment, the quality and nature of relationships, and the quality of said environment in providing necessary roles and functions that guide growth and development.
3. Negative or traumatic watershed experiences.
4. Defining and attaining human needs.
5. Possession of, or deficits in, protective and resilient factors.

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