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NOJOS Level Two: In-Home /Outpatient Sex-Specific Therapy

Client Profile

NOJOS Level Two: In-Home /Outpatient Sex-Specific Therapy youth not only need psychosexual information (outlined in NOJOS Level One above), but they also present with a need for targeted sex-specific clinical intervention. Typically, this is the first time these youth have every engaged in sexual misconduct or they may have successfully graduated from a higher level of care and now need ongoing outpatient Level Two services for step-down transitional, and aftercare purposes. These youth may present with a slightly greater frequency and duration of problematic sexual behavior and/or sexual misconduct than a Level One youth and thus, they fall in the *low risk or low-to-moderate risk level.*

Youth qualifying for this level of intervention typically have one or more victims, but usually do not have indiscriminate choice of victims (i.e., male, and female victims, related/unrelated victims and/or toddler and peer/adult victims). Their sexual behavior may have been more intrusive, but nevertheless, showed minimal evidence of progression from less-intrusive to more-intrusive sexual behaviors over time/across victims. Additionally, these youth typically meet one or all of the following: 1. lack of consent, which means one of the parties does not a) understand what is proposed without confusion or trickery; b) know the standard for sexual behavior in the culture, the family and the peer group; c) possess awareness of possible consequences including stigma, punishment, pain and disease; and d) have respect for the agreement or disagreement without repercussions; and/or 2. a lack of equity between parties, meaning there is an inequality in the authority, power and control within the relationship; and/or 3. the presence of coercion, meaning pressure to comply (either explicit or implied) has been exerted in order to get someone else to do something (Bonta and Andrews, 2016).

Overall, these youth are disclosing and acknowledge some accountability for their sexual misconduct (although not always and often not initially). They generally display feelings of guilt or shame, although they do not always demonstrate empathy, either due to their developmental stage or lack of understanding of the impact of sexual behavior on others, or they have comorbid neuropsychological barriers that have prevented their development of empathy. These youth typically present with adequate community support, are willing and able to comply with safety restrictions and are usually amenable to treatment.

The majority of these youth are *low risk and/or low-to-moderate risk* as assessed by nationally recognized risk assessment tools. The significant difference between youth who qualify for outpatient sex-specific clinical intervention and those requiring more intensive intervention lies in the protective factors, resiliency and internal and external assets of these youth and the availability of a competent caregiver with current capacity to provide adequate safety, supervision, and guidance.

In limited circumstances, these youth may present with a moderate level risk; however, the youth's family or caregivers are able and willing to provide appropriate supervision and comply with treatment recommendations, and it is determined that this supervision provides an acceptable protective factor to reduce the youth's risk. These youth typically do not present with a strong pattern of oppositional behavior or conduct disorder; however, they may present with other comorbid diagnoses including clinically significant depressive symptoms, anxiety and/or impulsivity/attention problems.

Overall, youth who qualify for Level Two Outpatient Sex-Specific Psychotherapy intervention typically present with more protective factors both internally, and in their family system and home environment, as well as their meso-system (school, church, social group, neighborhood etc.) These youth also often have higher levels of resiliency and internal assets that help lower and offset their risk.

Treatment Focus and Goals

NOJOS Level Two: In-Home /Outpatient Sex-Specific Therapy interventions should provide individual and family therapy, as needed, offering traditional adjunct mental-health services (with individualized dosage and variations in focus, model, and duration) and sex-specific services. Group therapy may be appropriate *in some circumstances but not always necessary for this level of intervention*. Level Two providers should provide sex abuse-specific interventions, cognitive behavioral content, risk management, and strength-based skill building. Identified sex-specific treatment issues or goals include increases in the youth's adaptive levels of functioning behaviorally, emotionally, socially, cognitively, and psychologically. In addition to these goals, the youth should improve their executive functioning, social competency and relatedness, use of social skills in demonstrating mastery in their environment, as well as stabilization of behavior in social, school and home settings.

Sex-specific treatment also often includes modules based on healthy living and decision-making, increasing self-monitoring of behavior, understanding thoughts, feelings, behaviors, and consequences associated with sexual misconduct, and strategies for managing inappropriate sexual behavior, etc. (David S. Prescott and Robert E. Longo, *Current Perspectives: Working with Young People Who Sexually Abuse,* Current Perspectives: Working with Sexually Aggressive Youth & Youth With Sexual Behavior Problems, Longo, Robert E. & Prescott, David S., Editors, NEARI Press, 2006, page 52).

Given that current research suggests exposure to pornography is now a common (developmentally expected) experience for both latency age and adolescent youth, psychoeducation about pornography is often needed to help adolescents think critically about pornography rather than solely focusing on teaching abstinence. Specifically, treatment should include a realistic, balanced, rational, developmentally sensitive, and individualized approach to address pornography use, in the same manner that other risk factors would be addressed. Treatment should help youth assess whether images and practices shown in pornography are realistic reflections of sexual relationships, consensual, or behaviors desirable to, and respectful of, sexual partners, and characteristic of physically and psychologically healthy social or sexual relationships. (See Bridges et al., 2010; Lim et al., 2017; Pratt & Fernandes, 2015; Prescott &

Schuler, 2011; and Wright et al., 2015.) [ATSA Fact Sheet: Understanding and Responding to Pornography Use Among Adolescents Who Have Engaged in Sexually Abusive Behavior: Facts and Considerations for Practice, August 2020]

Psychoeducation points to consider in treatment interventions related to pornography include:

> 1.Pornography portrays sexual performances and behaviors that are generally scripted and unreal, depicted by actors, and not representative of real-life sexual behavior or healthy, safe, enjoyable sexual experiences for all involved parties; 2. In many scripted pornography scenarios, sexual practices that are depicted are unhygienic, aggressive or violent, and if used in actual sexual practice, may result in physical or emotional injuries; 3. Pornography depicts aggression, in particular aggressive sexual behaviors, as desirable to all involved parties, when this is not the case in most real-life sexual relationships; and 4. Pornography may negatively impact body image due to the use of actors who do not represent 'average' physical norms. (See Bridges et al., 2010; Lim et al., 2017; Pratt & Fernandes, 2015; Prescott & Schuler, 2011; and Wright et al., 2015.) [ATSA Fact Sheet: Understanding and Responding to Pornography Use Among Adolescents Who Have Engaged in Sexually Abusive Behavior: Facts and Considerations for Practice, August 2020.]

Overall, the goal for NOJOS Level Two: In-Home /Outpatient Sex-Specific Therapy is to assist the youth to increase competency and skills necessary to ensure their ability to control or eliminate etiological and maintenance factors influencing their pathway to offend, re-establish a healthy developmental trajectory (in all developmental stages), obtain their needs and human goods in a healthy way and place themselves back on a healthy pathway towards becoming a functional, healthy and happy adult (Ward, T.; Polaschek, D. and Beech, A. Theories of Sexual Offending, John Wiley & Sons, Ltd. 2006). [See also Good Lives Model, Yates & Prescott, 2011; .]

Treatment Modalities

Based on the youth's presenting problems and needs assessment. Outpatient sex-specific treatment can vary in focus, intensity, duration, and frequency. This is typically related to the youth's response to treatment as well as their ability to obtain primary human goods or common life goals (See Good Life Model Treatment Goals including living and surviving, learning, and knowing, being good at work and play, personal choice and independence, peace of mind, relationships, and friendships, being part of a group or community, spirituality and having meaning in life, and happiness and creativity, Yates & Prescott, 2011). Nevertheless, this Level of treatment must include psychosexual education **and** targeted sex-specific therapy at least weekly for the specific risk factors and etiological deficits identified in a comprehensive sex-specific assessment as contributing to the youth's sexual misconduct. Traditional mental-health therapy interventions should also be included to address the youth's other comorbid psychological issues.

Family therapy should focus on family dynamics associated with the youth's misconduct and/or problematic functioning, as well as supervision, safety planning and assisting the youth to manage

his/her risk. Family therapy should also include education of the parents/caregivers[3] regarding the youth's current risk factors, treatment goals and supervision needs and skills to provide healthy sexual development after treatment ends. Indeed, it is critical to view the parent(s)/guardian(s) as part of the treatment team and empower them to be active participants in the youth's treatment process. If there is a greater degree of conflict or problems in the youth's home environment, more frequent and/or intensive family therapy should occur focused specifically on these family issues.

Monitoring and Safety Plan Compliance

The NOJOS certified sex-specific clinician(s), and parents (and other informed caregiver(s)/ supervisors, case worker, etc.) act as a clinical intervention team to ensure the youth's compliance and progress in the treatment program. A safety plan and/or supervision guidelines are recommended to be implemented in the youth's home to ensure environmental and community safety. The safety plan and supervision guidelines should identify those informed adults who have been approved to supervise the youth, contact restrictions (if any), restrictions around bathroom use, hygiene practices (bathing, dressing, etc.), nighttime routines, caretaking responsibilities and involvement in, and supervision of, extracurricular (academic, community, family, religious) activities.

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