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Taking a Developmental Approach to Treating Juvenile Sexual Behavior Problems

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Abstract

While theories on the etiology of sexually problematic and offending behavior have become increasingly developmental in their perspective, treatment approaches that are utilized to address these issues have not significantly changed to address this thinking. Adolescent behavioral problems are especially linked to a wide range of personal and developmental factors that can often be marginalized or overlooked when taking a behavior management approach to address these issues. This article presents an argument for treatment that explicitly places problematic sexual behavior in a developmental context. This approach prioritizes the assessment of developmental strengths and deficits and identifies treatment progress as the acquisition and integration of developmental skills and not just the absence of problematic behavior. Special consideration is given to research on the impact of trauma and attachment disruptions on neurodevelopment and overall developmental progress.

Keywords

Sexually abusive youth, juvenile sexual behavior problems, sexual abuse treatment, developmental treatment, neurodevelopment, attachment, trauma-informed treatment

While theories on the etiology of sexually problematic and offending behavior have become increasingly developmental in their perspective (Chaffin & Friedrich, 2000; Stinson & Becker, 2013; Ward & Gannon, 2006; Ward & Seigert, 2002;), treatment approaches, especially those directed toward juveniles, have not significantly changed in a manner that reflects this thinking. Surveys of treatment providers continue to identify cognitive-behavioral treatment as the primary and best treatment approach for adolescents (and adults) with sexual behavior problems (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010), despite the fact that our understanding of child and adolescent brain development, adolescent learning, and the impact of trauma on neurodevelopment and behavior has grown dramatically over the past decade.

Research that points to improved treatment outcomes when families are involved in the treatment process (Borduin & Schaeffer, 2002; Huey, Henggeler, Brodino, & Pickrel, 2000) should also serve to remind us that adolescent behavioral problems are greatly influenced by the adolescent's family and social environment as well as the demands that are inherently present in all adolescent development. Rather than separating our understanding of adolescent sexual behavior problems, and our treatment of the adolescents themselves, from our understanding of what promotes "normal," healthy adolescent development, I believe it makes more sense to embed our treatment perspective and our treatment goals firmly within the framework of what we know fosters growth and resilience in child and adolescent development.

Why a Focus on Development?

Using the "normal" developmental process as the basic framework for treatment provides a number of advantages. Perhaps first and foremost it reminds the treatment provider and the broader systems involved with these youth (juvenile justice, social welfare, educational) that adolescence is a developmental period of considerable growth and change and that many of the difficulties that we are prone to identify in our clients (e.g., limited empathy, self-absorption, easily influenced by peers, taking limited responsibility for personal behavior, high degree of interest in sex, accessing pornography, etc.) are also problems for many other adolescents who do not have serious behavioral difficulties. This is not to argue that the youth we treat do not have significant behavioral and emotional issues, but it is a reminder that the process of development and maturity is "on our side" and some of the issues that we pathologize in adolescents who enter treatment also exist, to a greater or lesser degree, in most adolescents and may diminish or resolve without significant therapeutic intervention.

A developmental framework for treatment also provides considerable guidance for identifying and targeting those particular issues or deficits in skills that create obstacles to a positive developmental trajectory. The basic premise behind all developmental theory is that development proceeds from the simple to the complex, and that the positive engagement in early developmental tasks leads to the acquisition of skills and traits that provide the foundation for higher level skill acquisition and the ability to engage in and carry-out more complicated tasks in later development. In utilizing an understanding of normative childhood developmental as our treatment framework, we are looking to assess for the "foundation" skills that may be missing or limited in the particular adolescent we are treating, and this directs the treatment provider in prioritizing the focus of our interventions. This approach also leads us away from a "one size fits all" model of treatment and facilitates a more individualized treatment approach since the developmental experiences and the level of foundation skills and deficits is likely to look different for different adolescents.

Utilizing a developmental framework also clearly informs our understanding of what constitutes "progress" in treatment and helps the treatment provider, the family, and others in the involved system maintain a holistic focus on the needs of the adolescent and his/her family. Quite often, the various systems that are involved with these youth are largely driven by a behavior management approach in conceptualizing treatment, treatment goals, and treatment progress, rather than the broader goals of a more holistic approach to treatment. More specifically, the adolescents we treat are identified for treatment because they have engaged in a particular, or, more frequently, a variety of problematic, abusive, or illegal behaviors. Treatment progress is therefore most typically identified and measured by the degree to which the identified problematic behaviors either diminish or desist. The most obvious example of this would be to measure the success of particular treatment programs or particular treatment interventions by their ability to produce lower rates of recidivism for abusive and illegal sexual behaviors and in some instances lower rates of general delinquent or illegal behaviors. While lowering or eliminating the amount of abusive or illegal sexual behavior in which these youth engage is clearly a legitimate, important, and even primary goal of treatment, we should also acknowledge that it is a very narrow goal, and especially when considered in the context of research that indicates already low sexual recidivism rates for most adolescents (Reitzel & Carbonell, 2006, for example). I would posit that the system's focus on a behavior management view of sexual behavior problems has led to the creation of treatment programs for these youth where progress is measured by "the absence of bad" rather than the acquisition and growth of the necessary, adaptive, and pro-social developmental skills and experiences required for these adolescents to move forward in their lives in a positive and competent manner.

Adopting a developmental approach suggests that treatment goals focus, not only on eliminating bad behavior, but also upon promoting and facilitating: (a) the presence of stable and supportive family relationships, (b) the presence of a stable and safe living environment, (c) the adolescent's ability for self-regulation, (d) the ability to engage in adaptive, pro-social problem solving, (e) the development of academic and/or vocational competence, (f) the capacity to make and sustain positive pro-social relationships, and (g) the capacity for intimacy and an understanding of healthy sexuality. It would also mean that research on long-term treatment outcomes is set up to capture and measure (at least to some extent) the presence or absence of these developmental goals in the lives of the children and adolescents we treat.

I believe it is fair to argue that a focus on these broader developmental goals will not only serve to address the issues of problematic and abusive sexual behavior, but will also more directly address the significantly higher rates of recidivism in general and non-sexual delinquent behavior that current

research has identified for this population (Caldwell, 2007, 2010; Letourneau & Miner, 2005). More importantly, a focus on developmental treatment goals is more consistent with our goals for adolescents in our society in general and does not equate a positive, successful, or "good" life with simply not harming others or staying out of jail.

How Trauma Can Impact Development

Emotional and behavioral regulation, promoted by a sense of safety and parental engagement, are important developmental foundations for pro-social functioning. Numerous studies have identified the immediate and long-term effects that a wide range of adverse experiences, some of which may be viewed as specifically traumatic, can have on child development (American Academy of Pediatrics, 2002; DeBellis et al., 1999; Egeland, Sroufe, & Erickson, 1983; Maughan & Cicchetti, 2002; National Child Traumatic Stress Network, 2003; Perry, 2001; Teicher, Andersen, Polcari, Andersen, & Navalta, 2002). These adverse childhood experiences may include pervasive neglect, emotional abuse, physical abuse, sexual abuse, exposure to family violence, parental substance abuse, parental mental health problems, and loss of immediate family members through death or abandonment. Some of the developmental problems associated with the child's experience of persistent stressors include attachment difficulties, academic problems, poor peer relationships, developmental delays, and significant deficits in self-regulatory functioning and inhibitory control (DeBellis et al., 2009; Granic & Patterson, 2006; Raine et al., 2005; Schwartz, Cavanaugh, Prentky, & Pimental., 2006; Stinson & Becker, 2013).

Schwartz et al. (2006) document the evidence that high levels of neglect, family violence, psychological abuse, physical abuse, and sexual abuse are experienced by large percentages of adolescents identified with serious aggressive and sexual behavior problems. The Centers for Disease Control, through their ongoing ACES study (see Middlebrooks & Audage, 2008), has shown that cumulative harm appears to develop as a child is exposed to a higher number of instances of adverse experiences. While I am not arguing that every adolescent who engages in problematic or abusive sexual behavior necessarily has a history of abuse, neglect, or exposure to family violence, I would argue that those adolescents who present the greatest level of systemic challenges and concerns, as well as the greatest risk for future sexual and non-sexual offenses, are adolescents who present with these experiences.

Many of the individual and social problems that have been associated with adverse or traumatic childhood experiences can also be related to the neurodevelopmental impact of neglect and abuse on brain regions associated with interpersonal attunement/attachment, emotional and behavioral regulation, and adaptive problem solving. These include the amygdala, H-P-A axis, anterior cingulate cortex, hippocampus, different regions in the prefrontal cortex, and broader left hemisphere development (DeBellis, 1999; Perry, 2001; Teicher et al., 2002; Raine, Mellingen, Liu, Venables, & Mednick, 2003; Raine et al., 2005). The obstacles and influence generated by these neurological processes are, I believe, essential factors to consider, not only in understanding the etiology of child and adolescent sexual and other serious behavioral problems, but also in developing treatment programs and treatment interventions that allow youth to more effectively learn and integrate new experiences and skills into their capacity for meeting the demands of everyday living in a pro-social manner.

Attachment and Development

A common factor that lies at the intersection of neurodevelopment, emotional and behavioral self-regulation, social development, capacity for intimacy, traumatic experiences, and the risk for engaging in delinquent or antisocial behavior is the presence (or absence) of a consistent, supportive, emotionally available adult relationships in a child's life. This is especially true of early parent-child secure attachment relationships that lay the foundation for the social and regulatory responses required for later pro-social adaptive functioning (Bowlby,1969; Hart, 2011; Schore, 2002; Sroufe, 2000).

The presence or absence of secure attachment relationships has not been identified through research as directly determining those individuals who will engage in sexually abusive behavior or differentiating individuals who commit sexual offenses from non-sexual offenders. However it is noteworthy that integrated models for understanding the etiology of sexual offending frequently point to the role that parent-child relationships play (Barbaree, Marshall, & McCormick, 1998; Marshall & Marshall, 2000; Prentky et al., 1989; Smallbone & Dadds, 2000; Ward & Seigert, 2002) or more recently to the neurological dysregulation resulting from the lack of secure attachment relationships (Stinson & Becker, 2013; Ward, Polaschek, & Beech, 2006) in the development of sexually abusive behavior.

Numerous theorists and researchers have pointed out that one of the most important functions of the human attachment system is to generate a system for self-regulation within the child. Hart (2011) writes:

> *In the attachment relationship, the child learns to regulate emotions through interactive affect regulation, which helps differentiate neural patterns. The goal is to increase the capacity for self-regulation, which enables the child to simultaneously be himself or herself and to be in touch with the other in a relationship. (Hart, 2011, p. 3)*

As we are focusing on increasing our clients' capacity for emotional and behavioral self-regulation, it is important that we understand that the experience of secure attachment in relationships is a central element in facilitating the growth of these capacities. It should not be surprising that in examining the research on resiliency in childhood, or when identifying factors that protect against engagement in future delinquent behavior, the presence of a stable caring relationship with at least one other person is often cited, along with a capacity to self-soothe and a sense of personal competence, as a key protective process (Egeland, Carlson, & Sroufe, 1993; Masten & Coatsworth, 1998; Resnick et al., 1993; Widom, 1991).

Research from the National Child Traumatic Stress Network (2003) notes that the seven most frequent types of developmental insults contributing to post-traumatic behavioral difficulties in children include: emotional abuse (59%), loss of important relationships (56%), impaired caregivers (47%), exposure to domestic violence (46%), sexual abuse (41%), neglect (34%), and physical abuse (28%). I suggest that at least five of these "developmental insults" directly involves disruptions in the parent-child attachment relationship and, depending on the circumstances of an individual case, all seven of these factors may specifically involve parent-child interactions.

Because of the importance of attachment relationships in facilitating broader neurodevelopment, disruptions or direct insults to early attachment relationships, such as parental abuse and neglect, can also have the effect of creating obstacles to experiencing personal competency and mastery. DeBellis et al. (2009) note that childhood experiences of abuse and neglect can lead to a range of learning disabilities, including significantly lower IQ and specific problems in reading, mathematics, complex visual attention, visual memory, language, verbal memory and learning, planning, and problem solving. Research has shown that 30% or more of children who have suffered abuse and neglect develop specific learning difficulties (Streeck-Fisher & van der Kolk, 2000). In a study of the Vermont Correctional System (2000), 95% of youth under age 22 incarcerated in the adult prison system lacked a high school diploma and 48% had a history of special education in school.

Given that positive engagement in school and the development of personal competency are among the strongest protective factors for youth at risk for problematic and antisocial behaviors, learning issues can present as an important and frequently overlooked obstacle to treatment progress. Appreciating the role that attachment relationships can play in facilitating school engagement and cognitive performance is an important factor in addressing these issues.

Translating a Developmental Perspective into Assessment and Treatment

If there is agreement that a holistic view of the adolescents we treat most effectively informs our understanding of their current behavior and future risk for sexually abusive behavior, it also appears that viewing the youth within the context of his or her developmental history and optimal developmental trajectory is an essential underpinning for the entire assessment and treatment process.

Incorporating a Developmental Approach into the Assessment Process

Integrating a developmental approach into the assessment process largely entails utilizing information regarding normative developmental skill acquisition as the baseline for evaluating an individual client's strengths and weaknesses. This does not preclude the gathering of information involved in a more typical assessment of adolescents with sexual behavior problems. The assessment will still involve gathering information about the reported problematic sexual behavior, family history, school history, social history, cognitive functioning, etc. What may prove different is that our interpretation of this information is now focused on how these behaviors or experiences either enhance or create obstacles to pro-social growth and development. Also, information from specific test instruments such as personality inventories, intelligence tests, and other normed scales can be incorporated and provide some reference of the individual's functioning when compared to other adolescents of the same or similar age. Additionally, current instruments designed to structure the clinician's assessment of risk for future sexual offenses such as the JSOAP-II, the ERASOR, or the J-SORRAT-II, continue to be viewed as useful tools, although, arguably, these tools are inherently limited because, by design, they identify collective risk factors rather than individual dynamics (Latham & Kinscherff, 2012).

We would argue that the research on adolescents with behavioral problems suggests that the more typical assessment battery will additionally include an evaluation of specific trauma symptoms (e.g., Trauma Symptom Checklist for Children, Child Post-Traumatic Symptom Scale), an adaptive behavior/life skills scale (such as the Vineland or the Casey Life Skills Assessment), testing for executive functioning skills (for example, the Behavior Rating Inventory of Executive Function, Wisconsin Card Sort, or the Conner's Continuous Performance Test), and a sensory assessment or sensory screening completed by or in conjunction with an occupational therapist (OT). A sensory assessment is helpful because many clinicians fail to consider sensory issues in the children and adolescents they evaluate, and symptoms are often overlooked or more simply viewed as another aspect of disrupted or dysregulated behavior. Ideally, an OT would be available for at least a screening for all youth, or the clinician will include a basic screening instrument in the assessment process. Although these additional instruments are aimed at assessing for a wide range of specific trauma and neurological conditions, they also yield a sense of each youth's capacity to function at a developmentally expected level and are targeted at those issues that frequently create significant developmental obstacles for behaviorally troubled youth.

An important aspect of the assessment process is gaining information, either through direct observation or through feedback from the client, family, school, and other involved parties, regarding the client's observed developmental competencies in relation to his or her chronological age. It is important to engage in this process with clients, families, schools, etc., because it is frequently the case that when developmental deficits are present, they are not necessarily global in nature. That is, individuals may present as developmentally "on track" in several aspects of their life (such as social interests or physical coordination) and yet have significant, but sometimes less visible, gaps in other developmental areas (for example, language skills, and accurately reading social cues).

There are a variety of resources available that identify specific developmental skills (physical, cognitive, social-emotional) that are generally related to different developmental periods in a child and adolescent's life (e.g., Victoria State Government, 2008; Institute for Human Services, 2007). Utilizing such a reference as a framework for discussing the youth's current functioning, integration of expected developmental gains, and developmental progress can achieve a variety of goals.

1. It places the adolescent's current functioning into context and often informs parents and other involved parties about realistic expectations and typical issues for children at particular developmental stages.
2. It allows for a more holistic view of the adolescent that identifies strengths as well as weaknesses, and also identifies deficits or obstacles that may not have been attended to or not previously recognized.
3. It can stimulate discussion with the client and the family regarding events or experiences in the adolescent's life that may have inhibited, enhanced, or influenced development at particular ages.
4. It helps the evaluator to place the adolescent's sexual behaviors and understanding of appropriate sexual behavior into a developmental context.
5. It helps identify and prioritize the focus of treatment and treatment goals.
6. It provides an ongoing framework for recognizing and measuring treatment progress.

Using a developmental perspective as the framework for guiding assessment not only encourages the clinician and the client to focus on adaptive and pro-social functioning as the goal of treatment, rather than just the "absence of bad," but also encourages the other involved systems to adopt a similar focus. I have found that adopting a developmental perspective during the assessment period can also enhance family engagement and openness to a greater extent than an assessment process that is largely framed by pathology and behavioral problems.

Adding a developmental focus to assessment, including the evaluation of sexual risk, broadens and deepens our perspective, and allows us to see each youth as a person in the midst of a developmental process. In turn, this focus, and the resulting view of the client, can not only help us to better assess the possibility of future troubled behavior, but also evaluate what the young person may need in treatment, and what can be expected of the young person entering treatment.

Treatment in the Context of the Developing Brain

Adopting a developmental framework not only helps in identifying treatment needs and establishing treatment priorities, but also can help specifically guide the treatment process and treatment interventions. When considering a treatment plan and treatment interventions, we have come to use the sequence of brain development and child development as an indication of where to focus treatment priorities and how to best facilitate the delivery of treatment interventions. As with the developmental process in general, this means a focus on foundation skills and experiences before more complex tasks and the utilization of treatment modalities that move from the bottom (body based, sensory based and experiential) to the top (analytical and insight oriented).

The Basics of Brain Development

During fetal development, neurons are created and migrate to form the various parts of the brain. As neurons migrate, they also differentiate, so they begin to "specialize" in response to chemical signals (Perry, 2002). This process of brain development occurs in a specific sequence from the most basic parts to the most complex parts. The lower brain (brainstem and cerebellum) develops first. The brainstem is responsible for basic survival functions like breathing, heartbeat, and reflexes while the cerebellum is responsible for controlling physical movement, balance and coordination. The limbic system develops next and is responsible for the processing of emotions, while the cerebral cortex develops last and is responsible for conscious, voluntary action.

Along with this bottom to top orientation for brain development, there is simultaneously a developmental process moving from the right hemisphere to the left hemisphere and from the back of the brain towards the front of the brain. In broad terms, the right hemisphere of the brain is more focused on global tasks while the left hemisphere is more focused on logic and analysis. Typically tasks like facial recognition, spatial orientation, color recognition, music, rhythm, rhyme, and art are considered right hemisphere dominant tasks and these tend to be prioritized in early infancy. Skills such as language, logic, sequencing, and analysis are considered more left hemisphere dominant and generally emerge later and more gradually. In addition, when examined from back to front, there is a sequential development of the visual cortex, the somatosensory cortex, the auditory cortex, the motor cortex, and then the pre-frontal cortex that tends to guide the way in which infants experience and interact with the world around them.

When considering the executive functions of the pre-frontal cortex, the *right pre-frontal cortex* is involved in the task of recognizing faces and the

meaning of expressions; interpreting others emotions from tone, posture, and gesture; reacting appropriately to negative tones and gestures; and interpreting stimuli and coordinating the feelings of risk states. These skills provide a basis for the more analytic executive functions of the left pre-frontal cortex. The *left pre-frontal cortex* is engaged in analyzing information; planning and preparing to execute plans; identifying obstacles and adjusting solutions; interpreting experiences and modifying emotions; and controlling impulses and deciding how to meet needs (Siegel, 1999).

We feel that the process of brain development provides something of a template for how developmental tasks and experiences are best learned and integrated. Reminding ourselves of this process can substantially inform our understanding of what treatment needs might take priority and what modalities might best facilitate treatment for different issues or at different points in the treatment process.

A Developmental Approach to Treatment

A developmental approach to treatment utilizes our understanding of tasks associated with different developmental stages and our understanding of neuro-development and neuro-processing to create the framework for treatment. In treatment, this means attending to the earliest developmental tasks first (attunement, attachment, body awareness, physiological regulation, and accurate reading and interpretation of social cues) before moving to higher level developmental tasks, such as learning and integrating social rules and skills, higher levels of personal responsibility, and understanding the impact of my behavior on others. The acquisition of these skills can then lead to addressing still more complex issues such as understanding the dynamics of individual behavior, active and adaptive resolution of family and social conflicts, the development of empathy and broader moral development. Obviously, in treating adolescents with sexual behavior problems many of these issues must be addressed simultaneously; nevertheless, a developmental perspective suggests that for the adolescent to effectively integrate and independently utilize higher level skills, he or she must first experience and build competencies in the "foundation" skills.

An understanding of neuro-development directs the clinician and the system as a whole to work toward treatment interventions that are multi-modal in nature. For instance, if, through assessment, the client is seen as having deficits in early developmental skills such as self-regulation and accurately reading social cues, this should direct us to consider more body based or sensory-based treatment interventions, over an immediate or exclusive use of more cognitive based interventions. This would mirror our "bottom to top, right to left, back to front" understanding of how skills such as social attunement, negotiating personal space, and regulating physiological arousal are first learned and integrated. As another example, research on the impact of trauma has indicated that one consequence of childhood trauma can be a lack of left hemisphere development, and also deficits in left-right hemisphere integration (Teicher et al., 2002). This may mean that many of the adolescents with whom we work are better at visual learning and kinesthetic or experiential learning than they are at verbal learning. Relying exclusively or heavily on "talk therapy" may, in fact, limit treatment progress for many clients. Educational research also indicates that all adolescents are likely to be more engaged in the learning process, and better able to integrate information, when it is presented in a variety of modalities (Jensen, 2000).

It is important to note, that the assessment and treatment process identified above does not suggest that every adolescent starts treatment with a focus on the same treatment issues or with the same treatment interventions. Rather, the clinician should start treatment with an understanding of the adolescent's developmental deficits/gaps and strengths with the goal of facilitating pro-social growth and progress. As with normal child development, the more limited the developmental capacities the greater the need will be for adult engagement, direction, structure, and supervision. Conversely, a higher degree of developmental skills would suggest a focus on later developmental tasks, such as personal responsibility, improved independent decision-making, pro-social peer interaction, and a greater degree of moral development. As stated earlier, the adolescents we treat frequently present with a high level of developmental competencies in some areas, but also with significant gaps in others. The difficult task for the clinicians, families, teachers, and others involved with these youth is creating the proper balance among the family, school, and social contexts of the youth's life in order to enhance the developmental strengths of each youth while "back-filling" enough of the early developmental experiences to provide the necessary foundation for future growth and progress.

Accordingly, applying a developmental framework to treatment, or viewing the client through a developmental "lens," can help us, not only to better understand our clients and their behaviors, but also what they need in treatment, and when and how to build and deliver treatment interventions.

Integrating a Developmental Approach with Risk, Needs, and Responsivity

Bonta and Andrews (2010) write that interventions with individuals exhibiting externalizing, criminal behavior are most effective when the intensity of services is determined by the individual's risk factors and when treatment targets risk-relevant dynamics. In addition, they highlight the importance of providing services in a manner that recognizes and is responsive to individual learning styles and learning needs. The principles of Risk-Needs-Responsivity (RNR) have become a central component in the development of treatment programs for adult sexual offenders (for instance, see Looman & Abracen, Wilson & McWhinnie, and Yates, this issue), and to a somewhat lesser degree are identified in the formulation of treatment programs for adolescents.

Among the primary difficulties in effectively translating RNR principles to the treatment of adolescent sexual abusers is that the research on risk factors for adolescent sexual recidivism is quite unclear and frequently conflicted (McCann & Lussier, 2008; Spice et al., 2013; Worling & Långström, 2006). Further, many of the risk factors presenting the greatest predictive strength for sexual re-offending cannot be distinguished from risk factors related to non-sexual offending (Cottle, Lee, & Heilbrun, 2001). Given the lack of clarity resulting from various meta-analyses of risk factors for adolescent sexual abuse that have yielded different results and conclusions, in many ways it seems more productive to examine individual developmental progress, family dynamics, developmental insults, personal competencies, and offense-specific dynamics to make a determination of risk for each particular adolescent. While this assessment can clearly be informed by factors identified in previous research (e.g., atypical sexual interests, early exposure to pornography, antisocial peer group, etc.), it strikes me that these issues would emerge anyway as concerns in an individualized assessment that focused on an adolescent's developmental trajectory.

An assessment and treatment process that views sexually troubled adolescents in the context of normal adolescent development is quite compatible with and remains guided by RNR principles. Indeed, a developmental perspective takes into account the risk for continued troubled behavior, the individualized needs of each client and obstacles to pro-socially meeting these needs, and the likely responsivity of each youth to different forms of treatment at any given point. From this perspective, *risks* are viewed as risks to successful, pro-social development, whereas *needs* are viewed in the context of the resources, supports, and experiences that each adolescent requires in order to successfully manage his or her specific developmental needs and demands. A developmental approach to treatment directly leads us to addressing issues of *responsivity* (e.g., neurological issues, learning disabilities, learning style, co-morbid mental health problems, cultural issues, etc.) as an essential aspect of our initial assessment.

A developmental approach is, therefore, consistent with the principles of risk, need, and responsivity, and in fact advances the meaning and value of each principle when each young person is seen through a developmental lens.

Conclusion

While I'm sure that most clinicians and treatment programs working with adolescents exhibiting sexual behavior problems would say that they take a holistic approach to treatment, and that they regularly consider adolescent developmental issues in their assessment and treatment of their clients, my experience tells me that quite often basic developmental needs and issues are not considered in placement and treatment decisions involving these

youth. This seems especially true for the adolescents whose lives are more significantly determined by decisions made by larger involved systems (juvenile justice, social service, education). By using our understanding of healthy, normative child and adolescent development to explicitly guide our treatment of these adolescents, I believe we increase our understanding of the etiology of sexually abusive behavior; we become more successful at individualizing treatment; we make better, more rational, and more consistent systemic interventions; and we offer clearer direction, support, and motivation for the adolescents and families that we treat.

References

American Academy of Pediatrics. (2002). *The Psychological Maltreatment of Children – Technical Report.* Retrieved online from *http://pediatrics.aapublications.org/content/109/4/e.68.full.html*

Barbaree, H., Marshall, W., & McCormick, J. (1998). The development of sexually deviant behavior among adolescents and its implications for prevention and treatment. *Irish Journal of Psychology, 19,* 1-31.

Bonta, J., & Andrews, D. A. (2010). Viewing offender assessment and rehabilitation through the lens of the Risk-Need-Responsivity Model. In F. McNeill, P. Raynor, & C. Trotter (Eds.), *Offender supervision: New directions in theory, research and practice* (pp. 19-40). Oxon, UK: Willan Publishing.

Borduin, C., & Schaeffer, C. (2002). Multi-systemic treatment of juvenile sexual offenders: A progress report. *Journal of Psychology and Human Sexuality, 13,* 25-42.

Bowlby, J. (1969). *Attachment and Loss. Volume I: Attachment.* New York: Basic Books.

Caldwell, M. F. (2007). Sexual offense adjudication and sexual recidivism among juvenile offenders. *Sexual Abuse: A Journal of Research and Treatment, 19,* 107-113.

Caldwell, M. F. (2010). Study characteristics and recidivism base rates in juvenile sex offender recidivism. *International Journal of Offender Therapy and Comparative Criminology, 54,* 197-212.

Cottle, C., Lee, R., & Heilbrun, K. (2001). The prediction of criminal recidivism in juveniles: A meta-analysis. *Criminal Justice and Behavior, 28,* 367-394.

De Bellis, M. D., Hooper, S., Spratt, E., & Woolley, D. P. (2009). Neuropsychological findings in childhood neglect and their relationships to pediatric PTSD. *Journal of the International Neuropsychological Society, 15,* 868-878.

DeBellis, M. D., Keshavan, M., Clark, D., Casey, B., Giedd, J., Boring, A., Frustaci, K., &Ryan, N. (1999). Developmental traumatology. Part II: Brain development. *Biological Psychiatry, 45,* 1271-1284.

Egeland, B., Carlson, E., & Sroufe, L. A. (1993). Resilience as process. *Development and Psychopathology, 5,* 517-528.

Egeland, B., Sroufe, L. A., & Erickson, M. (1983). The developmental consequences of different patterns of maltreatment. *Child Abuse and Neglect, 7,* 459-469.

Friedrich, W. & Chaffin, M. (2000). *Developmental-systemic perspectives on children with sexual behavior problems.* Paper presented at the Association for the Treatment of Sexual Abusers conference, San Diego, CA.

Hart, S. (2011). *The impact of attachment.* New York: Norton Press.

Huey, S., Henggeler, S., Brodino, M., & Pickrel, S. (2000). Mechanisms of change in Multi-systemic Therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of Consulting and Clinical Psychology, 68,* 451-467.

Institute for Human Services (2007). *Developmental milestones chart.* Retrieved online from: www.rsd.k12.pa.us/Downloads/Development_Chart_for_Booklet.pdf

Jensen, E. (2000). *Different brains, different learners: How to reach the hard to reach.* San Diego, CA: The Brain Store.

Latham, C. and Kinscherff, R. (2012). *A developmental perspective on the meaning of problematic sexual behavior in children and adolescents.* Holyoke, MA: NEARI Press.

Letourneau, E. J. & Miner, M. H. (2005). Juvenile sex offenders: A case against the legal and clinical status quo. *Sexual Abuse: A Journal of Research and Treatment, 17,* 293-312.

Marshall, W. L. & Marshall, L. E. (2000). The origins of sexual offending. *Trauma, Violence, and Abuse: A Review Journal, 1,* 250-263.

Masten, A. & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful and unsuccessful children. *American Psychologist, 53,* 205-220.

Maughan, A. & Cicchetti, D. (2002). Impact of child maltreatment and inter-adult violence on children's emotion regulation abilities and socio-emotional adjustment. *Child Development, 73,* 1525-1542.

McCann, K., & Lussier, P. (2008). Antisociality, sexual deviance, and sexual reoffending in juvenile sex offenders: A meta-analytical investigation. *Youth Violence and Juvenile Justice, 6,* 363-385.

McGrath, R. Cumming, G., Burchard, B., Zeoli, S., & Ellerby, L. (2010). *Current practices and emerging trends in sexual abuser management: The Safer Society 2009 North American Survey.* Brandon, VT: Safer Society Press.

Middlebrooks, J. S., & Audage, N. C. (2008). *The effects of childhood stress on health across the lifespan.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

National Child Traumatic Stress Network. (2003). *Report of the Complex Trauma Task Force.* Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress.

Perry, B. (2001). The neurodevelopmental impact of violence in childhood. In Schetky, D. and Benedek, E. (Eds.), *Textbook of Child and Adolescent Forensic Psychiatry* (pp. 221-238). Washington, D.C.: American Psychiatric Press

Perry, B. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind, 3,* 79–100.

Prentky, R. A., Knight, R. A., Sims-Knight, J. E., Straus, H., Rokous, F., & Cerce, D. (1989). Developmental antecedents of sexual aggression. *Development and Psychopathology, 1,* 153-169.

Raine, A., Mellingen, K., Liu, J., Venables, P. H., & Mednick, S. A. (2003). Effects of environmental enrichment at 3-5 years on schizotypal personality and antisocial behavior at ages 17 and 23 years. *American Journal of Psychiatry, 160,* 1627-1635.

Raine, A., Moffitt, T., Caspi, A., Loeber, R., Stouthamer-Loeber, M., & Lynam, D. (2005). Neurocognitive impairments in boys on the life-course persistent antisocial path. *Journal of Abnormal Psychology, 114,* 38-49.

Reitzel, L. R., & Carbonell, J. L. (2006). The effectiveness of sexual offender treatment for juveniles as measured by recidivism: A meta-analysis. *Sexual Abuse: A Journal of Research and Treatment, 18,* 401-421.

Resnick, M., Harris, D. L., & Blum, R. (1993). The impact of caring and connectedness on adolescent health and well-being. *Journal of Pediatrics and Child Health, 29,* 53-59.

Schore, A.N. (2002). Dysregulation of the Right Brain: A Fundamental Mechanism of Traumatic Attachment and the Psychopathogenesis of Posttraumatic Stress Disorder. *Australian and New Zealand Journal of Psychiatry,* 36, 9-30.

Schwartz, B., Cavanaugh, D., Prentky, R., & Pimental, A. (2006). Family violence and severe maltreatment in sexually reactive children and adolescents. In R. Longo and D. S. Prescott (Eds.). *Current Perspectives: Working with sexually aggressive youth and youth with sexual behavior problems* (pp. 443-472). Holyoke, MA: NEARI Press.

Siegel, D. (1999). *The developing mind: Toward a neurobiology of interpersonal experience.* New York: Guilford Press.

Smallbone, S. & Dadds, M. R. (2000). Attachment and coercive sexual behavior. *Sexual Abuse, 12,* 3-15.

Spice, A, Viljoen, J., Latzman, N., Scalora, M., & Ullman, D. (2013). Risk and protective factors for recidivism among juveniles who have offended sexually. *Sexual Abuse, 25,* 347-369.

Sroufe, L. A. (2000). Early relationships and the development of children. *Infant Mental Health Journal, 21,* 67-74.

Stinson, J., & Becker, J. (2013). *Treating sexual offenders: An evidence-based model.* New York: Guilford Press.

Streeck-Fischer, A. & van derKolk, B. (2000). Down will come baby cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development. *Australian and New Zealand Journal of Psychiatry*, 34, 903-918

Teicher, M., Andersen, S., Polcari, A., Andersen, C., & Navalta, C. (2002). Developmental neurobiology of childhood stress and trauma. *Psychiatric Clinics of North America, 25*, 397-426.

Vermont Department of Corrections (2000). *Facts and Figures: FY 2000.* Retrieved from Vermont Department of Correction website: http://doc.vermont.gov/about/reports/ff-archive/facts-and-figures-2000/view

Victoria State Government (2008). *Child development and trauma guide.* Retrieved from Victorian state government website: www.dhs.vic.gov.au/everychildeverychance.

Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive Good Lives Model of treatment for sexual offenders. *Aggression and Violent Behavior, 11,* 77-94.

Ward, T., Polaschek, D., & Beech, A. (2006). *Theories of sexual offending.* West Sussex, England: JohnWiley & Sons.

Ward, T., & Seigert, R. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime, and Law, 8,* 319-351.

Widom, C. (1991). Avoidance of criminality in abused and neglected children. *Psychiatry, 54,* 162-174.

Worling, J., & Långström, N. (2006). Risk of sexual recidivism in adolescents who offend sexually: Correlates and assessment. In H. E. Barbaree & W. L. Marshall, W. L. (Eds.), *The juvenile sex offender* (2nd ed.) (pp. 219-247). New York, NY: Guilford.

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