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Functional Analytic Psychotherapy with Juveniles who have Committed Sexual Offenses

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Abstract

We have previously discussed the application of Functional Analytic Psychotherapy (FAP) with adults who have committed sexual offense behaviors (Newring & Wheeler, 2010). The present entry borrows heavily from the foundation presented in that chapter, and extends this approach to working with adolescents, youth, and juveniles with sexual offense behaviors. We synthesize what is known about adults who exhibit sexual offense behavior, sexual offense behaviors exhibited by adolescents, and the application of FAP to adults and adolescents. We then discussion how FAP can be used when working with adolescents who exhibit sexual offense behaviors, to address those factors that have been empirically-associated as relevant to a youth's risk of sexual or violent reoffense.

Keywords

Sexual offense, juvenile, dynamic risk, FAP

The results of a recent meta-analysis (Reitzel & Carbonell, 2006) indicate that approximately 19% of adolescents who did not receive specialized, sexual-offense-specific treatment were subsequently charged for a sexual reoffense after a follow-up period of approximately 5 years. In contrast, approximately 7% of adolescents who received sexual-offense-specific treatment were charged with a new sexual offense during the same time period. Thus, participation in treatment to address sexual offense behavior reduces sexual offense recidivism by almost two-thirds.

Like other forms of therapeutic intervention, treatment for juveniles who commit sexual offense behavior (henceforth referred to as JSOs) was adapted from interventions that had been developed for treating adults who had committed sexual offense behavior. With regard to therapy for adults who have committed criminal offense behavior, including sexual offense behavior, current best practice emphasizes the principles of *Risk*, *Need*, and *Responsivity* (*RNR*; Andrews & Bonta, 1998). Briefly, the *Risk Principle* states that the level of intervention is matched to the assessed level of recidivism risk level of the client; a low risk client should receive relatively less intervention, whereas a high-risk client should garner relatively more intervention. Applied to treatment for juveniles, the *Risk Principle* suggests that more resources should be allocated to juveniles whose sexual offenses were motivated by an underlying interest in sexually deviant themes (i.e. use of force, attraction to pre-pubescent children), and/or juveniles with a long-standing history of delinquent behavior.

The *Need Principle* states that effective treatment should focus on "*criminogenic needs*," also known as "*dynamic risk factors*," i.e. factors that have are statistically associated with recidivism, and which are amenable to change. Applied to treatment for juveniles, the *Need Principle* suggests that therapeutic interventions should be focused on the emotions, attitudes, and behaviors that facilitate a generally "delinquent" or "*non-prosocial*" lifestyle, such as anger/aggression/negative affect, substance use, stability of school and social functioning, negative peer influences, and an unstable/unsupportive family environment.

The *Responsivity Principle* refers to the use of empirically based treatment approaches and delivery of treatment in a manner that takes into account the individual needs of the client (learning style, cognitive ability; Dowden & Andrews, 2000). This principle discourages therapists from using poorly theorized approaches (e.g., psychoanalysis) or administering treatment programs in a mechanistic "one size fits all" fashion to improve treatment outcomes. Applied to treatment for juveniles, the *Responsivity Principle* suggests that treatment should be tailored to adapt to the client's level of physical, cognitive, social, emotional, and psychosexual development (Newring et. al 2010).

There are many variants of the *RNR* approach, both in program design and delivery (Polaschek, 2011). Andrews and Bonta (2010) recently reported that *RNR* approaches have been shown to reduce offender recidivism by up to 35%. In their recent meta-analysis, Hanson, Bourgon, Helmus, and Hodgson (2009) found strong support for the application of *RNR* to sexual offender treatment programs. *RNR* approaches are being used successfully with sexual offenders (Harkins & Beech, 2007), intellectually disabled sexual offenders (Keeling, Beech & Rose, 2007), and personality-disordered violent forensic clients (Wong, Gordon, & Gu, 2007).

NEW DIRECTIONS IN TREATMENT FOR SEXUALLY OFFENSIVE BEHAVIOR

Positive and collaborative approaches. In recent years, traditional confrontation-based and avoidance-focused treatment approaches have been challenged (Marshall, Ward, Mann, Moulden, Fer-

Table 1. Risk Assessment Domains for Juveniles with Sexual Offense Behaviors

"Antisocial" dynamic risk-needs: (General problems that can get you in trouble with authority and/or could hurt someone else). These non-sexual, "antisocial" risk needs include emotions, attitudes, and behaviors that facilitate a generally "delinquent" or "non-prosocial" lifestyle, including the following:	
General self-regulation deficits: (Problems managing your feelings and behaviors)	
J-SOAP-II	Pervasive anger, Management of anger
ERASOR 2.0	Interpersonal aggression; Recent escalation in anger or negative affect; Poor self-regulation of affect and behavior (impulsivity)
General pro-social functioning deficits: (Problems between you and your community)	
J-SOAP II	Caregiver consistency; School behavior problems, Conduct Disorder; Juvenile antisocial behavior, Empathy (general); Remorse and Guilt (general); Cognitive distortions (criminal/antisocial); Quality of peer relationships; Stability of current living situation; Stability in school; Evidence of positive support systems
ERASOR 2.0	Antisocial interpersonal orientation; Lack of intimate peer relationships/social isolation; Negative peer associations and influences; High-stress family environment; Problematic parent-offender relationships/parental rejection
Rule violation/non-compliance: (Problems following the rules)	
J-SOAP-II	Accepting responsibility for offenses; Internal motivation for change; Understands risk factors and applies risk management strategies
ERASOR 2.0	Parents not supporting offense-specific treatment; Environment supporting opportunities to re-offend sexually; No development/practice of realistic prevention plan/strategies; Incomplete treatment
"Erotopathic" dynamic risk needs: (Sexual/dating problems that can get you in trouble with authority and/or could hurt someone else). Some juveniles have sexual-specific risk needs that contribute to their risk to re-offend sexually. These "erotopathic" risk-needs are the emotions, attitudes, and behaviors that may facilitate harmful, illegal, deviant, or otherwise problematic sexual behavior and/or non-prosocial romantic behavior, including the following:	
Sexual self-regulation deficits (Problems managing your sexual-self)	
J-SOAP-II	Sexual Drive/Preoccupation, Management of sexual urges and desire
ERASOR 2.0	Deviant sexual interests, Obsessive sexual interests/Preoccupation with sexual thoughts
Romantic intimacy deficits (Problems with dating relationships)	
J-SOAP-II	Empathy (for partner); Quality of (romantic) peer relationships
ERASOR 2.0	Lack of intimate peer relationships/social isolation; Interpersonal aggression (with romantic partner)
Attitudes supportive of sexual offending (Thinking errors about sex and dating)	
J-SOAP-II	Accepting responsibility for offenses; Internal motivation for change; Empathy (for victim); Remorse and Guilt (about offense); Cognitive distortions (about offense)
ERASOR 2.0	Attitudes supportive of sexual offending; Unwillingness to alter deviant sexual interests/attitudes)

nandez, Serran, & Marshall, 2005; Wheeler, 2003; Wheeler, George, & Marlatt, 2006; Wheeler, George & Stoner, 2005). While acknowledging the need to identify and manage risk for the individual offender, new approaches are more strength-based, and emphasize the importance of therapeutic alliance. For example, Marshall et al. (2005) assert that working collaboratively with the offenders towards these goals will enhance treatment compliance and maximize treatment effects. More recently, sexual offender treatment has increasingly moved towards such strength-based approaches, which expand upon the *RNR* approach, such as the *Good Lives Model* (*GLM*; Wilson & Yates, 2009), and the *Self-Regulation* model (Mann, Webster, Schofield, and Marshall, 2004; Ward & Hudson 2000; Ward & Stewart, 2003). There is some empirical evidence to support that approach-goals may be more salient factors in clients' risk to sexually re-offend (Hudson, Ward, & Marshall, 1992; Ward, Hudson, & Marshall, 1994; Wheeler, 2003).

The underlying premise for strength-based models is that motivation for sexual behavior can often be linked to a common human need, such as affiliation, mastery, competence, efficaciousness, emotional intimacy, or physical pleasure. Most individuals develop skills that provide them with opportunities to fulfill these normative human needs in a manner that is effective, adaptive, and not harmful to others. However, some individuals may lack the agency to be interpersonally effective in sexual encounters with same-aged peers. In order to fulfill an otherwise normative human need to affiliate and feel competent, individuals who lack skills for engaging in prosocial sexual relationships may resort to sexual relationships that are characterized by coercion, exploitation, manipulation, or even force. Thus, the goals clients are pursuing in the *Good Lives model* are those normative human motivators, either establishing operations, antecedents or consequences, common across clients (and people) which lead to maladaptive behaviors to obtain said goods (e.g., intimacy, agency, competence).

Dynamic risk factors. The last decade of research on sexual offense behavior has resulted in significant gains in our understanding of numerous personality and lifestyle variables associated with sexual recidivism risk. As described previously, the term

"*dynamic risk factor*" (*DRF*) refers to those aspects of an individual's behavior or environment that are associated with increased likelihood to re-offend, and that are potentially subject to change. Accordingly, if a *stable dynamic factor* can be reduced in treatment, this may affect longer-term change in an individual's re-offense risk. Although research on dynamic factors is an ongoing process, these preliminary findings provide a basic framework for integrating dynamic risk factors into extant approaches to sex offense treatment.

Currently, available data indicate that dynamic risk factors for sexual offense recidivism appear to be associated with one of two broad categories: (a) a pathological orientation towards love and sex, or "*erotopathic risk-needs*" (Wheeler, George, & Stephens, 2005; Wheeler, George, & Stoner, 2005) or (b) a generally *antisocial orientation* (Hanson & Morton-Bourgon, 2004; Hanson & Bussiere, 1998; Hanson & Harris, 2001; Hudson, Wales, Bakker, & Ward, 2002; Quinsey, Lalumiere, Rice, & Harris, 1995; Roberts, Doren, & Thornton, 2002).

"*Erotopathic risk-needs*" refer to the dynamic risk factors that are associated with the development and maintenance of maladaptive sexual behaviors and romantic relationships, e.g. with minors, or through the use of force), and avoidance of partners who challenge his control. For juvenile clients who present with dynamic risk factors in this area, treatment should focus on building behavioral skills and activities to develop and maintain developmentally appropriate dating/sexual relationships, which would be decrease their likelihood of pursing more exploitative/abusive methods for meeting these needs. From an applied behavior analytic perspective, this approach is consistent with a differential reinforcement of alternative (or incompatible) behavior that achieves the same or similar acquisition of the desired outcome, at a more palatable social cost for the treatment participant and society. In the following pages, we present behaviorally specific examples germane to empirically identified risk factors.

The second broad category of dynamic risk factors, or "*antisocial risk needs*" (Wheeler, George, & Stephens, 2005; Wheeler, George, & Stoner, 2005), refers to the dynamic risk factors that are associated with the development and maintenance of a chaotic, irresponsible, defiant, or otherwise antisocial lifestyle. A growing body of literature in the field suggests that the dynamic risk needs of juvenile offenders are similar to those of non-sexual juvenile offenders, and that it is these (non-sexual) needs that may be most relevant for intervention. Accordingly, for juvenile clients who present with dynamic risk factors in this area, treatment should focus on building behavioral skills and activities to develop and maintain a satisfying and prosocial lifestyle, which could serve to curtail future acts of sexual offending.

For those practitioners working with adolescents who have engaged in sexual offense behavior, several assessment instruments are available to help identify dynamic risk factors and treatment targets, including the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II; Prentky, & Righthand, 2003), The Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling, 2004), and the Youth Level of Service/Case Management Inventory (Hoge, Andrews, & Leschied, 2002). Two of the most popular and researched assessments for juveniles with sexual offense behaviors are the ERASOR 2.0 and the J-SOAP-II, with the YLS-CMI geared more towards juveniles who have committed non-sexual offenses. Currently, the ERASOR 2.0 is viewed as an acceptable instrument for use with males and females that have engaged in sexual offense behavior. The J-SOAP-II is currently recommended for males only, with on-going research exploring the appropriateness and effectiveness of that measure with adolescent females with sexual offense behaviors. With some consideration, these measures are easily adapted for use in treatment settings (see Cuadra, Viljoen, & Cruise, 2010; Wheeler & Covell, 2007), to identify clients' treatment needs and appropriate targets for intervention.

The table below is a summary of risk items from the J-SOAP-II and the ERASOR 2.0, identifying common risk factors across instruments, and organizing them into similar themes and constructs.

FAP AS A USEFUL APPROACH TO TREAT SEXUAL OFFENSE BEHAVIOR

Consistent with the collaborative, positive, and idiographic approach emphasized by Marshall (2005) and Marshall et al. (2005), Functional Analytic Therapy (FAP; Kohlenberg & Tsai, 1991; Tsai et. al., 2008) offers an effective approach to identify and target clients' dynamic risk needs in the context of sex offense treatment. In the FAP model, clients' needs are identified and operationalized into behaviorally specific treatment targets (clinically relevant behaviors or CRBs), with interventions designed to increase desired behavior, reduce undesired behavior, and promote generalization beyond the therapy room. (Newring & Wheeler, 2010)

As many dynamic risk-needs relevant for sexual offense recidivism are related to behavior and expressed attitudes, behavioral approaches appear most applicable in addressing these risks. Furthermore, most dynamic risk factors for sexual offense recidivism are rooted in interpersonal domains (i.e. romantic, sexual, and/or social relationships), so an interpersonal psychotherapeutic approach is consistent with addressing these risks. Given these contingencies, FAP is well suited for clinical use with adolescents with sexual offense behavior(s). While it unlikely for a client to engage in-session in topographically similar problematic sexual behaviors that occur outside of session (O1s) or improvements that would occur outside (O2s), it is quite likely that the client will engage in functionally similar in-session problematic behaviors (CRB1s) and in-session improvements CRB2s) when those behaviors are similarly occasioned. For example, when faced with distressing interpersonal conflict 'in the world,' a client may turn to sexualized coping though masturbation, impersonal sex, or use pornography or other topographically similar sexual problem solving (O1 and O2); in the therapeutic context, the demands may inhibit an overtly sexual coping response yet may evoke a response that works similarly, such as sexualized talk, directed conversation towards a previous sexually inappropriate act (CRB1 or CRB2), that would function in the same sexually self-soothing manner as would more overtly sexual behavior.

FAP's focus on the assessment and conceptualization of functional classes maps on well to the risk areas outlined in dynamic risk assessments for sexual offense behavior. FAP's emphasis on the clinically relevant examples of the behavior, including

topographical and functional, speaks towards the probabilistically more frequent functional analogues to sexual misbehavior in therapy, relative to the probabilistically less frequent overt exemplars of sexual misbehavior. By combining the functional aspects of behavior (FAP) with the most relevant treatment domains (assessed dynamic risk related to sexual recidivism), the inclusion of FAP in treating sexual offense behavior is ideal for the interpersonally based dynamic risks for the juvenile offender. Using FAP terminology, these areas of dynamic risk-needs may capture functional classes of behavioral excesses of deficits, or exemplars of these risk areas may speak towards classes of CRBs. In sex offense treatment, CRBs should be related to identified risk-needs, and identified risk factors, if present, should be related to CRBs. Accordingly, FAP rules can be applied to guide the clinician in noticing, evoking, and reinforcing clinically relevant client behavior related to the client's risk for sexual re-offense. As a reminder, the FAP rules are:

Rule 1: Watch for Clinically Relevant Behaviors (CRBs). In FAP, CRBs are noted as instances of the problem or target behavior (CRB1), instances of improvements related to the problem or target behavior (CRB2), or behavior (verbal or otherwise) about a CRB1 or CRB2 without being an instance of a CRB1 or CRB2 in and of itself (CRB3). The following section provides general guidelines for instances of clinically relevant behavior associated with relevant areas of dynamic risk related to adolescent sexual offense recidivism.

Rule 2: Evoke CRBs. FAP therapists may attempt to evoke improvements, or work to create the *opportunity* for the client to demonstrate improvement. For a behavior to be reinforced, the behavior needs to occur. For clinically relevant and low frequency behavior, the clinician may need to create opportunities for the client to demonstrate improvements. Ideally, such evocations will be natural and sincere.

Rule 3: Naturally reinforce CRB2s. As many of the dynamic risks for sexual offense behavior are related to interpersonal behaviors, skills, or interactions, the therapeutic relationship is a prime context in which salient reinforcement and punishment can be delivered on clinically relevant behavior. As a reminder, the intention of the therapist or the topography of the behavior does not determine its reinforcing properties (e.g., praise is only reinforcing when it functions to reinforce a specific behavior contingently). What determines the reinforcing properties is the observed impact of the therapist-delivered response.

Rule 4: Notice the therapist's effect on the client. Related to Rule 3 above, clinicians are to notice their impact on the client, not just their intended impact on the client. As a therapist, one may have many stimulus properties for clients--be attractive, remind them of a prosecutor or judge, have similarities to a former sexual partner, be the first one to demonstrate a consistent and caring disposition, be the first person in their life who matters to them, and who they allow themselves to care about. The impact therapists have on their clients may change over time, and may change in accordance with the level of attachment and intimacy developed between the therapeutic dyad. The therapist might be intending to reinforce or punish an exemplar of a class of behavior – whether or not this effect occurs is for the therapist to observe.

Rule 5: Provide functional interpretations of client behavior. To promote the generalization of CRB2s from the therapy room to the world in which the client lives, functional interpretations assist the client in shifting from rule-governed approaches (e.g., avoid parks, avoid schools) to function-governed approaches (e.g. approach relationship-enhancing discussions, discuss emotions with the support team to foster communication).

There are important differences between working with persons convicted of sexual offenses and non-offending clients. To highlight some of these differences, we offered the following FAP principles for working with persons convicted of sexual offenses (Newring & Wheeler, 2010):

Principle 1: The client and therapist must matter to each other for FAP to work in reducing risk to sexually re-offend.

Principle 2: Functional assessment informs treatment practices, and dynamic risk assessment informs functional assessment.

Principle 3: Reinforcement of prosocial behavior and punishment of antisocial/deviant behavior are functional not topographical. Shaping involves reinforcement and extinction.

Principle 4: Just because the problem is about sex doesn't mean that treatment is always about sex.

Principle 5: Even though treatment is not always about sex, it may still be addressing a problem that is about sex.

ASSESSING DYNAMIC RISK-NEEDS

In addition to the use of formal assessment instruments observable indicators of dynamic risk may occur regularly – in the living area, school, during recreational activities, and of course, in individual and group treatment sessions. Effective treatment depends on a therapist's ability to recognize when and how an individual's immediate problem behavior is related to his or her chronic dynamic risk needs. This will be a relatively straightforward task when the problem behavior is sexual in nature, and somewhat more challenging when the problem behavior is not overtly sexual. It is important to remember that many dynamic risk factors are not sexual per se, but they do contribute to the individual's overall risk to engage in harmful, illegal sexual activity (e.g. traits associated with psychopathic or narcissistic personality disorders). These are indicators of underlying dynamic risk factors to be targeted in treatment.

A clear conceptualization of the client's relevant dynamic risk factors for sexual re-offense and FAP Rules 1-5 can guide the clinician working collaboratively with the person convicted of sexual offense behavior. The dynamic risk areas can help generate the case conceptualization.

For the purposes of illustrating the general process of applying FAP to target dynamic risk needs, the following section provides a brief summary of the dynamic risk factors outlined in the ERASOR 2.0 and J-SOAP-II, including behavioral indi-

cators of these risk needs as O1s and O2s in daily life and as CRB1s and CRB2s in the treatment setting. While the following are based on topographical categories, there is value in illustrating how the standard categories of behavior can be addressed from a FAP perspective, thus the descriptions below to provide some examples of how sex offense specific CRBs may present themselves in the therapy process.

"ANTISOCIAL" DYNAMIC RISK-NEEDS (GENERAL PROBLEMS THAT CAN GET YOU IN TROUBLE WITH AUTHORITY)

GENERAL SELF-REGULATION DEFICITS (PROBLEMS MANAGING YOUR FEELINGS AND BEHAVIORS).

This construct focuses on the youth's experience and expression of anger, aggression, and impulsivity, and any related changes in their efforts to regulate their emotions. In gathering information about a youth's self-regulation, collateral information from siblings, care providers, educators, coaches, mentors, and others involved in the youth's day-to-day life can be illuminating. For example, school records may indicate several disciplinary referrals, and legal histories may include charges for assault, disorderly conduct, or threats. This construct also involves assessment of the youth's impulsivity. Structured assessment towards diagnostic criteria for Attention-Deficit/Hyperactivity Disorder can be useful. The youth may also provide indications of distractibility and inattentiveness during clinical interviews. Negative emotionality is a tendency towards feeling hostile, victimized, and resentful and feeling vulnerable to emotional collapse when stressed. For risk assessment purposes, it is important to emphasize that a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) is insufficient; rather, there must be indications that the youth has difficulty managing their mood and behavior. In sum, if a youth with a history of sexual offense behavior has difficulty managing his or her feelings and behaviors, they are considered to be at increased risk for using sexual acts in response to dysregulated affect. Youth that can effectively manage their emotions and behavior are considered to be at relatively lower risk for acts of sexual harm to others. Impulsivity is seen when the youth engages in impulsive behavior that has a high likelihood of negative consequences. For this item, consider the extent to which the adolescent is easily bored, seeks thrills and has little regard for personal safety or the safety of others. This behavior must be exhibited in several settings and not just represented by a history of sexual offending. In this section and those following we have provided a list of some of the possible outside (O1s and O2s) and clinically relevant (CRB1s and CRB2s) indicators of this need area:

- O1s and O2s. O1s might include fights with peers, threats towards siblings and parents, non-compliance with residential staff member directives, a change to or pervasive bad mood. O2s might include effective problem solving with peers, use of self-initiated time-outs or cooling off periods, use of relaxation skills.
- CRB1s and CRB2s. CRB1s might include verbal or physical aggression (or other behavioral extremes) directed at the therapist, staff or other group members; engaging in frequent conflict or "power struggles" with therapist, or peers during group; not participating during group (e.g. pouting), Possible CRB2s include demonstrating appropriate turn-taking in group, making appropriate solicitations for emotional assistance from staff and peers.
- FAP Techniques: For this and each of the following sections, the FAP moves involve using the FAP rules in a manner consistent with the approaches advised by Marshall (2005). From a warm and compassionate stance, address CRBs as they speak to relevant dynamic risk related to sexual recidivism risk. Identify and respond to the CRBs in a collaborative manner consistent with identification and reinforcing of approach-goals.

GENERAL PRO-SOCIAL FUNCTIONING DEFICITS (PROBLEMS BETWEEN YOU AND YOUR COMMUNITY).

The basic construct is: does the youth have durable, meaningful, pro-social and effective ties to their friends, family, school, and community. Information from the youth, family, school, probation officer, past therapists, and records can inform assessment in this domain. Behavioral indicators of this need area include:

- O1s and O2s. O1s rule violations at home, placements, and school, theft, truancy, running away, disregard of the rights and feelings of others, justifying anti-social acts, social isolation or socializing with non pro-social peers, family conflict, family turmoil, caregiver inconsistently, and problematic parent-child relationship. O2s include rule compliance at home and school, consideration shown for others (e.g., taking turns, sharing, volunteering, affiliating with pro-social peers, making emotional disclosures to peers (e.g., vulnerable confiding), cooperation with parents and teachers.
- CRB1s and CRB2s. Potential CRB1s disrupting group, encouraging in-group peers to avoid responsibility, affiliation with treatment-resistant peers, missing sessions, refusal to share/disclose during therapy group. CRB2s include encouraging peers to share emotional experiences, sharing emotional experiences, supporting treatment efforts, attending sessions, and establishing a safe and supportive treatment environment.
- FAP Moves. For a client reluctant to enlist social support, the therapist would watch for efforts at asking for help, or setting an instance in which the client could be motivated to ask for help. The natural reinforcement is the provision of social support when asked. The therapist would then look to see changes in client (withdrawing from the conversation, changing the topic, becoming further engaged, additional requests. The therapist might then comment on the impact and function of the client asking for help, and the client's behaviors once the help was provided.

RULE VIOLATION/NON-COMPLIANCE (PROBLEMS FOLLOWING THE RULES)

The basic construct is: Youth that are not motivated to follow rules, generally speaking, may have difficulty following specific rules. Youth that are not encouraged to do well in treatment typ-

ically do not do as well in treatment, other things being equal. Behavioral indicators may include the following:

- O1s and O2s. O1s rule violations at home, school, and in the community, parents not taking their child to session, parents refusing to participate in family therapy, parents not complying with supervision plan, youth eluding supervision plan. O2s taking responsibility for the sexual offense behavior(s), identifying their personal risk factors for re-offense and developing alternative behaviors, parents supporting treatment and supervision.
- CRB1s and CRB2s. CRB1s include denying responsibility for sexual offense behavior, lack of participation in treatment and safety planning, engaging in O1s in therapy (e.g., perpetuating discussions of sexual content for prurient rather than therapeutic purposes). CRB2s include verbalizing acceptance of responsibility for sexual offense behavior, parental attendance and involvement in therapy, in-session monitoring and intervention of risk behavior (e.g., youth awareness of preoccupation/arousal in-session), meaningful treatment participation.

EROTOPATHIC DYNAMIC RISK NEEDS (SEXUAL/DATING PROBLEMS THAT CAN GET YOU IN TROUBLE WITH AUTHORITY AND COULD HURT SOMEONE ELSE, OR BOTH HARMFUL AND COULD GET YOU INTO TROUBLE).

SEXUAL-SELF-REGULATION DEFICITS (PROBLEMS MANAGING YOUR SEXUAL-SELF).

The basic construct is: pre-occupation focuses on recurrent sexual thoughts and behavior that are not directed to a current romantic partner. The degree of casual or impersonal sexual activity may interfere with other prosocial goals or be perceived as intrusive or excessive by the offender. However, high levels of sexual preoccupation should be considered problematic even if the offender sees little wrong with his behavior. Deviant sexual interests could include, but is not limited to, sexual interest in [pre- or peri-pubescent] children, non-consenting adults [or minors], voyeurism, exhibitionism, cross-dressing, and fetishism. Behavioral indicators may include the following:

- O1s and O2s. O1s include masturbating excessively; include a history of seeking impersonal sex or masturbating when experiencing negative emotional states, engaging in sex-oriented internet use, such as sexually explicit sites, chat rooms; collecting and/or trading pornography (videos, magazines); O2s include discussing age-appropriate and healthy sexual outlets; identifying and discussing controlling variables (functional analysis) regarding precursors and consequences of healthy sexual behavior, include developing and practicing stress inoculation efforts (especially if involving FAP-consistent peer supports
- CRB1s and CRB2s. CRB1s include displaying excessive sexual content in typical conversations; exhibiting pre-occupation with own or other's sex crimes; verbally reporting disturbing sexual thoughts; introducing sexual themes or discussions out of context; include exhibiting verbal behavior that indicates sexual interest in pre-pubescent children; discussing use of force during sex; engaging in paraphilic activity; denying any sexual urges and interests; increasing frequency of discussion of fetishes during times of distress. CRB2s include indicating healthy and respectful acknowledgement of sexual urges and desires; developing healthy sexual values and behaviors; acquiring and demonstrating effective proactive and reactive interventions when aware of sexual preoccupation. CRB2s include demonstrating healthy coping skills when experiencing stressors in the moment during groups or sessions; discussing healthy sexual appetites and practices; engaging in open discussion of sexual interests and ongoing functional analysis of sexual practices when prompted by therapist.
- FAP Moves: The therapist should be attentive, yet non-aversive, in monitoring the client's emotional, physical, and even sexual arousal during session. If the youth is demonstrating some manner of physical, emotional, or physiological arousal, the therapist can prompt to youth to address it in a gentle manner (e.g., "it seems that you're shifting around a lot in your chair when we talk about healthy masturbation. Is there one of healthy self-soothing skills you could use right now to help you settle down? … Hey, that really seemed to work well for you, and it helped us get back on track. I appreciate you trying that new skill").

ROMANTIC INTIMACY DEFICITS (PROBLEMS WITH DATING RELATIONSHIPS).

The basic construct is: The general capacity to make friends and feel close to others. Clients deficient on this dimension would feel lonely and socially rejected, have few romantic relationships, have few emotionally close peer confidantes, and perhaps have a history of aggression with their romantic partner. Youth without deficits would feel emotionally close to friends and family. Behavioral indicators may include the following:

- O1s and O2s. O1s include a history of isolating from social interaction and relationships; endorsing symptoms of phobias associated with social behavior; engaging in leisure activities that do not require social contact (e.g. television, reading, video games, collecting); lacking peers in whom the youth can confide; withdrawing, distancing, alienating from family members. O2s include demonstrating affiliative and socially enhancing efforts in social settings.
- CRB1s and CRB2s. CRB1s include failing to engage in interpersonal interactions with other group members before, after, during group; exhibiting limited eye contact; speaking infrequently in group; exhibiting inappropriate verbal or other behavior; directing conversation to topics that have little relevance or interest to others; maintaining bad hygiene. CRB2s include demonstrating increased attempts (and successes) at interpersonal interactions with peers and therapists.

ATTITUDES SUPPORTIVE OF SEXUAL OFFENDING (THINKING ERRORS ABOUT SEX AND DATING)

The basic construct is: the youth does not see the sexual offense behavior as problematic, sees their sexual behavior and experiences as satisfactory, does not appreciate the harm done to their direct and indirect victims, and may go so far as to revel in the act, or discuss interest in engaging in similar behavior in the future. Behavioral indicators may include the following:

- O1s and O2s. O1s continued engagement in problematic behavior despite sanction (e.g. attempting to access victim or potential future victims, bragging about their behavior to peers, justifying their actions. O2s include attending treatment, accepting responsibility for actions, complying with court orders, participating in reparative or restorative justice efforts, engaging in reconciliation and reunification processes when appropriate.
- CRB1s and CRB2s. CRB1s denying responsibility for offense, enlisting support of others to justify sexual offense behaviors, denigrating victim(s), supporting peers that deny responsibility for sexual offense behavior(s). CRB2s include accepting responsibility for behavior, identification and intervention upon cognitive distortions in self and others when in treatment, promoting supportive accountability, discussing impact of their actions on others demonstrating application of risk reduction and safety planning in session.
- FAP Moves. Given the therapist's on-going case conceptualization for the client, the therapist may be looking to see improvements in the client's acceptance of responsibility for the sexual offense behavior. In session, the therapist may notice and comment on an improvement, (e.g., "it sounds like you are taking more ownership for your sexual offense behavior. That kind of responsibility lets me know that you are taking therapy seriously, and helps motivate me to want to help you succeed in treatment even more"). The therapist challenge is to make such a remark that is 1) contingent, 2) sincere (i.e., does not come off as "cheesy or corny"), and effective. If the client appears to shut down when given some manner of verbal praise, then the verbal praise did not function as the intended reinforcement of the client's verbalization of increasing acceptance for the sexual offense behavior.

WHAT DOES THIS LOOK LIKE IN PRACTICE?

Using FAP as an approach to treat sexual offense behavior is essentially similar to using FAP to treat any other behavioral problem. As with any behaviorally based approach, therapy begins with case conceptualization. Using FAP as an approach to treat sexual offense behavior has the added advantage of having research-identified risk factors to assist in the assessment and conceptualization of clinically relevant behaviors and functional classes. In practice, we look to see what the person gained by engaging in the harmful sexual practice (e.g., intimacy needs were met, aversive emotional state was avoided). Then the therapist notes which of these functional classes are consistent with identified risk factors, as well as for CRB1s and CRB2s related to the functional classes and class exemplars. Subsequently, the therapist observes the clients' behaviors and watches for CRBs, evokes CRBs, and contingently shapes CRBs in the context of a caring and supportive therapeutic relationship. Here are some examples of FAP questions that might occur in session:

THERAPIST FEATURES

The therapist behaviors associated with therapeutic change include being empathic, directive, respectful, flexible, attentive, confident, supportive, trustworthy, emotionally responsive, genuine, warm, rewarding, self-disclosing, encouraging participation, using humor, and instilling positive expectations (Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson, 2003; as cited in Page & Marshall, 2007). These behaviors, consistent with FAP, facilitate change with general psychotherapy clients and with persons convicted of sexual offenses. Likewise, the therapist behaviors that reduce therapeutic change include being rejecting, nervous, dishonest, uninterested, unresponsive, rigid, judgmental, cold, critical, authoritarian, defensive, sarcas-

Table 2. Examples of FAP questions during sexual offense behavior therapy with juvenile clients

- What do I do in here that makes you mad?
- What are some of the things you don't want to talk about?
- How is what we do like school? How is it different?
- What do you think about the judge (or prosecutor or probation officer) in your case? What do they do that bothers you? What would you like to say to them, but you can't?
- Who else have you told about your sexual offense behavior?
- Of all the things going on in your case, what are the hardest things to talk about?
- Why can you talk with me about these things, but you have a hard time taking with your friends and family about it?
- What do you do well with me that you struggle to do well with others? What are some areas in which you struggle with me?
- How is the relationship with me similar or dissimilar to relationships you have with other people?
- What do your friends think about all this?
- Are there things you're afraid of telling me in session? What are you doing with those fears and worries?
- What is sharing (emotional intimacy) like with us? What are you doing to keep that going or to stop it? What could I do?
- What would the conflicts (arguments/fights) you were having with your girlfriend (parent/sibling/caseworker) right before you offended look like with us, if we were having similar conflicts?
- Are there times in therapy or group when you want to get up and leave? What are those times, what were we talking about when that happened? Can we talk about that again now?
- What do you do to handle yourself when you find yourself being turned on (or horny, or other word the youth uses) or having sexual thoughts in session? Is that helping in the short term or long term or both?

tic, hostile and angry, manipulative, impatient, uncomfortable with silence, needing to be liked, and having boundary problems (Marshall, et al., 2003, as cited in Page & Marshall, 2007). These behaviors interfere with effective FAP and effective sex offense specific therapy.

When deciding to conduct treatment with persons who have exhibited sexual offense behaviors, it is important to ask yourself "why?" This therapy is often emotionally challenging, and offers limited short-term evidence of therapeutic success (particularly if the measure of "therapeutic success" is limited to whether or not a client recidivates). Some providers may be motivated by a desire to prevent the youth from committing any future offenses. Accordingly, providers should be willing and able to employ the empirically based treatment approaches that are designed to facilitate therapeutic change (cited above). For some therapists, this may pose a challenge, particularly if they equate being supportive in a therapeutic setting with supporting or condoning the offense behavior. Of the many challenges therapists can face is being able to conceptualize the client's inappropriate sexual behavior as the best he could do at that time, given his history and contingencies of reinforcement.

In their work on FAP with adolescents, Newring et. al (2010) recommended that clinicians should not *try* to matter in order to actually matter to their client, should be sincere, be consistent, be functional, and care. Adolescents can detect insincerity, and learn through repetition with contrasting outcomes (e.g., doing A often produces Y, but this time A led to Z, why is that?). Therapy that allows the client to have a predictable experience in which their actions will lead to predictable and desirable outcomes should be likely to be experienced as enjoyable and efficacious for all involved.

When facing such a therapeutic challenge, it may be important for therapists to ask themselves which is more important: to *actually* facilitate prosocial change in an individual's behavior using empirically-based therapeutic techniques, or to *feel* as though they have impacted the offender using other methods, such as communicating disapproval of sexual offense behavior, withholding support and understanding, or leveling further punishment. We argue that these types of behaviors are evidence of an important boundary violation, where the therapist is using the individual's treatment process to meet his or her own emotional needs (i.e. to express disapproval of sexual offense behavior and thus distinguish oneself as distinctly different from the client). More importantly, by approaching sex offense treatment from this perspective, therapists may be working in opposition to the more essential goal, which is reducing that individual's risk to re-offend. In other words, working effectively to treat sexual offense behavior demands that therapists set aside their personal opinions about what the offender has done in the past, so that they can facilitate therapeutic changes in the individual's behavior that will reduce his risk to re-offend in the future. In the words of Page and Marshall (2007), "Treatment with this population is not an opportunity to work out your own issues" (pg. 13).

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

In recent years, increased emphasis has been placed on working collaboratively with persons convicted of sexual offenses to help address more positively-oriented "approach goals," in addition to traditional avoidance-based treatment targets. In addition, there has been an explosion of research on sex offense risk assessment and risk-based treatment for offenders that have provided new directions for the field of sex offense evaluation and treatment. The result of these two movements is that treatment for sexual offense behavior is now focused on "doing what works," and focusing on "what matters" to reduce sexual offense recidivism.

FAP, at its core, is an intensely interpersonal psychotherapy in which the therapeutic relationship is both the context in which change occurs, and the meaningful agent that motivates and supports changes. As many of the dynamic risk factors for sexual offense recidivism are interpersonal in nature, FAP is ideally suited to direct treatment approaches when working collaboratively with juveniles adjudicated for sexual offending.

The challenges in working with adolescent clients convicted of sexual offenses are problems insofar as they impact the clinician's clinically relevant behavior. Can clinicians allow themselves to form a caring and therapeutic relationship with a juvenile with sexual offense behaviors? Can they allow such a client to matter to them? How can they go about forging a meaningful relationship with the client? Can they forgo topography and instead focus on clinically relevant functions as they promote community safety?

Functional Analytic Psychotherapy is an ideal approach for youth with sexual offense behaviors. FAP's focus on the function of the youth's sexual offense behavior, as well as risk assessment informed sexual offense analogues, allows the therapist to naturally and contingently address problematic behavior in-session, while motivating change in a healthy direction. FAP adds the "how" in doing what works on what matters.

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