

## WELCOME TO @ ISSUE:!

Written by treatment professionals, @Issue: analyzes and offers commentary on contemporary issues impacting juvenile justice. Regardless of your role in the juvenile justice system, we are sure you will find this bi-annual newsletter informative. This time @Issue: Trauma and Youthful Sexual Offenders. @Issue: is published by Edison court, Inc. which is the parent company of Mathom House and Ravenhill Psychological Services. Mathom House is an RTF committed exclusively to the treatment of juvenile sexual offenders. Ravenhill provides specialized case management and therapeutic services for at-risk juvenile populations. For more information about the programs of Edison Court, Inc., please visit [www.edisoncourt.com](http://www.edisoncourt.com).

We want to hear from you! Your feedback is valuable! Have an issue you want to see covered? You can e-mail your comments and suggestions to: [mharrison@mathomhousecare.com](mailto:mharrison@mathomhousecare.com).

## Trauma Informed Care for Juvenile Sex Offenders: Beyond The Vampire Myth

BY: DAVID ATTRYDE

One of the popular myths surrounding the field of sexual offending is the notion that every perpetrator of child sexual abuse was himself a victim. Some lay people even subscribe to the “vampire myth” that anyone who is sexually abused is likely to perpetrate in kind.

The reality is quite different and most victims of sexual abuse never commit sexual assault.

However, the notion of offenders often being abused or traumatized and somehow shaped to later abuse others is valid, especially when viewing trauma in a broader, more inclusive context. The definition of trauma as a single event, (or “large T”

DAVID ATTRYDE



trauma) such as a rape or terrorist attack has been widened to include “small t” trauma such as a childhood characterized by ongoing dysfunctional experiences. Studies have long shown that individuals in the criminal justice and mental health systems are far more likely to have a history of trauma than the general population. Mental health treatment providers are rightly expected to provide treatment and a residential milieu that is sensitive to the trauma histories and current PTSD symptoms of its clients. In reflecting on my career, I realize that while the phrase “Trauma Informed Care” is a new one, the notion of providing it is not.

As a residential counselor I was informed that many sexually abusive clients had been abused by previous care givers and authority figures and I was taught techniques and strategies to communicate and lead the clients accordingly. Skills such as appropriate communication, avoiding unnecessary power struggles, proactive versus reactive crisis management, de-escalation techniques, earning trust and building rapport were all emphasized because these were emotionally damaged young men who deserved to feel safe and respected.

Later as an individual and group therapist I learned to explore the life histories of the clients and found lives replete with sexual, physical or emotional abuse (or all of the above). I helped the clients complete an inventory of their experiences and, where capable, draw conclusions and insights into how their maladaptive coping skills ensured their survival but also sowed the seeds of interpersonal violence. I have also witnessed the therapeutic power of their healthy relationships with staff members who earned their trust and modeled respect, appropriate boundaries and conflict resolution.

Treatment providers have for years recognized the role of trauma in juvenile sexual offending. Countless residents have described how their own sexual abuse resulted in abuse reactive behaviors and-

“In reflecting on my career, I realize that while the phrase” Trauma Informed Care” is a new one, the notion of providing it is not.”

sexualized them years before they were intellectually or emotionally equipped to handle their sexual impulses. Many have spoken of being neglected or abused within blended families and subsequently assaulting step- or half-siblings to satisfy feelings of jealousy and anger in addition to gratifying emerging sexual urges. Many have recounted sexualized environments where they were exposed to pornography, saw adults having sex and experienced a lack of privacy and loose sexual boundaries where sexual acting out among children was encouraged. Others have suffered physical trauma, loss of parents, grandparents or siblings or parental abandonment.

In examining the histories of my clients, it has often struck me that many emerge from an apparent family tradition of multigenerational abuse but are the first to be held accountable for their misdeeds. Parents, grandparents, uncles, aunts all contributed to a cycle of trauma via neglect, poor sexual boundaries, abandonment, assaults etc. But only the 15 year old boy before me is removed from his home, placed against his will and held to account for offenses sometimes far less egregious than the sum of those committed against him. It is against this complex backdrop that we are asked to provide balanced treatment to children who are both offenders and victims; the “traumatizers” and the traumatized.



## Creating a Trauma-Informed Culture

BY: KRISTIN DE FOREST

With respect to residential treatment, the trend in service delivery has been to carefully place children at this most restrictive level of care only after other less restrictive,



KRISTIN DE FOREST

have been designed to address the special needs of children with histories of maltreatment and exposure to family and community violence. A fundamental premise of the Sanctuary Model® is that the treatment environment is a core modality for modeling healthy relationships among interdependent community members. This model is aimed at strengthening the therapeutic community environment and empowering clients to influence their own lives and communities in positive ways. This culture then sets the stage for the application of a trauma recovery framework and cognitive behavioral strategies to teach adolescents effective adaptation and coping skills to replace maladaptive cognitive, social, and behavioral patterns acquired as means of coping with traumatic and other stressful life experiences. This philosophy has challenged programs to reexamine their basic assumptions concerning the extent to which treatment environments promote safety and nonviolence across physical, psychological, social, and moral domains.

The prevalence of traumatic histories among the population of residential treatment centers underscores the need to recognize the role that such experiences play in the lives of the residents and the need for trauma-informed staff and interventions. The Sanctuary Model® seeks to develop a culture that embodies seven dominant characteristics:

**Culture of Nonviolence-** building and modeling safety skills and a commitment to higher goals. Everyday interactions between staff and residents model the importance of safety in all aspects. Although direct care staff are trained in proper restraint procedures, ideally, it should be rare that such an intervention is utilized. Model programs successfully strive to be “hands off” in which the residents and staff know that physical threats /violence is not tolerated. Verbal assaults

“ The prevalence of traumatic histories among the population of residential treatment centers underscores the need to recognize the role that such experiences play in the lives of the residents and the need for trauma informed staff and interventions.”

community-based alternatives have been exhausted. Consequently, it has been noted that children entering residential treatment have typically experienced a history of failed placements and/or therapeutic interventions, are more seriously disturbed, act out more aggressively, and have complex abuse-related symptoms. Within the past ten years, trauma-informed models such as Sandra Bloom’s Sanctuary Model®

and antagonism are also frowned upon, with healthy, assertive, and positive communication skills taught as replacements.

**Culture of Emotional Intelligence-** teaching and modeling emotional management skills and the integration of thoughts and feelings. Residents can be encouraged to learn ways to express their personal

experience (thoughts and feelings) in a constructive manner while learning how their behaviors and words affect others. It is important that they be educated on the impact they have had on others and be encouraged to be more aware of the needs of those around them.

**Culture of Social Learning** - building and modeling cognitive skills in an environment that promotes conflict resolution and transformation. Residents in treatment facilities should be surrounded by staff and other more advanced residents who exhibit healthy problem solving skills and methods of de-escalation during periods of conflict and emotionally laden interactions. They should be praised and rewarded for demonstrating the ability to handle conflicts with others respectfully. Those who struggle to grasp the environmental teachings may often begin to make improvements as they see their peers advance through the program, strengthen relationships with others, and gain increased privileges.

**Culture of Shared Governance**- creating and modeling civic skills of self-control, self-discipline, and administration of healthy authority. Staff must always be present to ensure the safety of the residential community, address maladaptive behaviors, role model healthy interactions, mentor the residents, and demonstrate the behavior and interactions of healthy authority figures. The residents should be equally involved in maintaining a safe and peaceful culture. They can role model for each other, encourage each other to progress through the program, and creatively problem solve when members of their community are exhibiting negative behaviors. Residents should have daily opportunities to address their community concerns and participate in "town hall" meetings to work together on common goals.

**Culture of Open Communication** - overcoming barriers to healthy communication, reducing acting-out, enhancing self-protective and self-correcting skills, teaching healthy boundaries. When physical acting-out and/or aggressive behavior is not tolerated, residents are forced to begin interacting verbally, expressing themselves respectfully in order to get what they want. With practice they will sharpen these skills and become confident in their ability to effectively express their thoughts and feelings.

**Culture of Social Responsibility**- rebuilding social connection skills, establishing healthy attachment relationships. Once residents begin to feel safe and participate in the shared governance of a program, they will begin to feel a sense of responsibility as

members of their residential community. As they take pride in their physical environment, the relationships they form with staff, and the mutually respectful interactions they have with their peers, they learn the importance of community and personal responsibility necessary for safe and healthy living.

**Culture of Growth and Change**- working through loss; restoring hope, meaning, and purpose. As they progress through the program completing assignments, strengthening relationships, reevaluating themselves, and persevering through emotionally difficult times, they will be able to experience the joys and pains of personal growth and change. They will gain confidence in their ability to make difficult decisions in their best interests and will gain the strength necessary to stand up for themselves against those in their lives who chose to sustain unhealthy behavior.

Model programs such as Mathom House have seen firsthand just how valuable and transforming an environment based on the above noted principles can be. Residents not only gain insight into their maladaptive behaviors and learn how to avoid recidivating, they learn about the principles of being healthy individuals and productive members of society which, in itself, helps protect against further antisocial and/or abusive behaviors.



## EMDR: Treating Trauma and Beyond

BY: MEG SELLERS

Eye Movement Desensitization and Reprocessing (EMDR) is an empirically-validated methodology which is guided by an information-processing model, and views pathology as based upon perceptual information that has been maladaptively stored.

Therefore, EMDR treatment focuses on the perceptual components of experience (affective, somatic, and cognitive) in order to expedite the accessing and processing of disturbing events and facilitate an attendant learning process. It is also used to strengthen internal resources so that the client is able to achieve desired behavioral and interpersonal change. EMDR utilizes an eight-step treatment that includes the use of bi-lateral stimulation (not limited to eye movements) to enable clients to reprocess dis-



“In a one-month follow-up one client raved “I feel so much better! I feel more at peace with myself...I feel more like a person- like I’m worth something....loved and cared about”

turbing thoughts and images. EMDR is an integrated model that incorporates aspects of psychodynamic, experiential, behavioral, cognitive, physiological, and systems therapies.

Historically, EMDR has been utilized most frequently for working with clients exhibiting symptoms of both acute and chronic PTSD resulting from ‘Big T’ traumas such as sexual and physical abuse, neglect, crime and combat. It can also be successfully used with those suffering from what could be termed a ‘small t’ trauma — memories of upsetting incidents which may continue to have a negative impact on one’s current functioning. However, a body of evidence is growing that shows that EMDR can also be helpful with phobias, nightmares, addictions, grief work, and self-esteem related problems.

Based on an abundance of research studies that support EMDR as an effective and long-lasting treatment, the United States Department of Defense and the Department of Veteran Affairs have issued new guidelines putting EMDR into the category of therapies with the highest level of evidence and recommending it for treatment of PTSD. Research has shown that three 90-minute sessions of EMDR treatment eliminates PTSD in 80-100% of civilians with a single trauma experience, including rape, accident, or disaster. A study funded by Kaiser Permanente reported that 80% of multiple trauma victims and 100% of single trauma victims had PTSD eliminated in an average of six sessions. A recent National Institute for Mental Health (NIMH) study reported that EMDR was superior to Prozac in treating trauma.

In the initial session, the client is asked to identify a ‘safe place,’ real or imaginary. Their ability to imagine themselves in this setting is then strengthened using some type of bilateral stimulation, such as electronic tapper, eye movements, auditory tones, alternating touches to the client’s hands, patty cake (for young children), etc. With the ‘safe place’ established in the initial session, the next session is devoted to desensitizing the painful memories. In order to do this, the client is led through a series of eight phases of the treatment protocol. The client is first asked to describe the image that represents the worst part of the memory, and to rate how distressing this memory is for them, on a scale of 0-10. They are then asked to identify the most salient negative thought or belief that they have about themselves in the present, based on that image (negative cognition), along with how they feel when they think



## About the Authors

**David K. Attryde, M.S., L.P.C.** The Vice President of Edison Court, Inc. has been working with offenders for 17 years and has presented at conferences on this topic. He is a Forensic Evaluator for the Bucks County Juvenile Court and a partner in Delaware Valley Forensic Psychological Services which administers Easton Manor, a state of the art re-entry facility assisting adjudicated sex offenders in making transition to independent living, as well as running other specialized mandated programs.

**Kristin DeForest, M.A., L.P.C.** is the Deputy Director of Inpatient Programs and Services for Mathom House with more than ten years experience treating juvenile sexual offenders. Kristin is trained in the use and interpretation of the Abel Assessment, and has been completing assessments since 2005. She is also a lead therapist for Easton Manor.

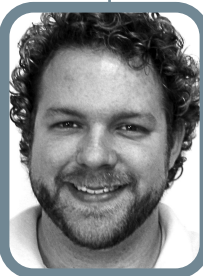
**Meg Sellers, M.Ed.,** has been a Clinical Therapist at Mathom House for over twelve years. She has more than 25 years experience in the counseling field working with a wide variety of clients, focusing on trauma victims of all ages. Meg has used EMDR extensively over the past eight years both in private practice and with offenders at Mathom House .

**Thomas A. Bortner, Psy.D.,** is a Clinical Therapist at Mathom House. He is trained and certified in the use of DBT. Dr. Bortner’s clinical dissertation was entitled “The Relationship Between Childhood Sexual Abuse and Subsequent Juvenile Sex Offenses”.

of the memory, and where in their body they experience these feelings. Lastly, they are asked what they would, instead, like to think of themselves when they think of that memory, and how strongly they currently believe that positive cognition. The client is asked to concentrate on the image, emotions, and negative cognition they identified, and the bilateral stimulation is initiated. After thirty seconds to one minute, the client is asked to report on what came to their mind, which may be a new thought, image or emotion, or a change in physical sensation. They are then asked to focus on that experience for the next set of bilateral stimulation. The client continues making statements indicating change in perception of the event after each successive set, finally reaching a point at which they begin to make statements indicating resolution. Statements indicating resolution might be the realization that they could not have stopped the situation from occurring, that they did the best they could, or that the situation was bad but occurred a long time ago; common emotions voiced are feeling in control, strong, or cared-about.

It can easily be observed that the vast majority of clients who undergo EMDR experience the eradication of negative thoughts or emotions in one or two working sessions (subsequent to installation of the Safe Place) when the target is a single trauma or series of similar re-occurring traumas. In a one-month follow-up one client raved “I feel so much better! I feel more at peace with myself...I feel like a person— like I’m worth something...loved and cared about.” Another said, “I don’t get angry anymore. I no longer get into arguments. I can also tell my mom how I felt about her while growing up, which I could never do before.” Still another reported “I have a vision of a golden light in me, which is strong whenever I need it. I see myself as filled with power. I also know now that I’m a good person.” Or, simply, “I feel happy now for the first time since I was abused.”

TOM BORTNER



## Treating the Traumatized Offender: The Balance of Behavior Change and Acceptance

BY: TOM BORTNER

Treatment models for the rehabilitation of juvenile sex offenders have progressed throughout history, partially following the incorporation and extinction of what has and has not proven its utility with regard to decreased recidivism, and partially reflecting what

has been identified in research (e.g., sex offender typologies, etc.). Contemporary models of sex offense specific therapy extend the treatment approaches of juvenile sex offenders to better incorporate the empirically supported understanding that juvenile sex offenders, like adult sex offenders, are a heterogeneous population. Understanding that not all juvenile sex offenders are the same, and that they are all the product of their own idio-

syncratic life experiences, the long adhered to “one size fits all” treatment approach has lost its appeal. Influenced by the philosophies that have been indicated in approaches such as Tony Ward and colleagues’ Good Lives Model, Sandra L. Bloom’s Sanctuary Model, and Robert E. Freeman-Longo’s Integrative approach, juvenile sex offense specific treatment weighs heavily the individual’s past life experiences. It could be argued that treatment sans a proper conceptualization of the individual lacks effectiveness as it does not consider potential factors, based on past life experiences, that need to be addressed when working to promote prosocial behaviors within an effective therapeutic framework.

With the multitude of experiences that a teenage boy charged with a sexual offense is likely to have encountered during his lifetime comes the potential for him having faced some variation of trauma likely of causing residual effects that might serve as an additional ongoing life stressor as well as interfere with the treatment process. Knowing that

“ Understanding that not all juvenile sex offenders are the same, and that they are all the product of their own idiosyncratic life experiences, the long adhered to “one size fits all” treatment approach has lost its appeal.”

the juvenile sex offender population consists of all walks of life that have experienced various levels of trauma, be it direct or indirect experiences of emotional, physical, and sexual abuse, be it a singular ‘big T’ trauma such as an eminent threat to one’s well

being or ongoing 'small t' stressors brought on by invalidating environments, how does one incorporate this understanding and apply it to the sex offense specific treatment process? Perhaps the answer lies within the current line of trauma focused therapies.

While not a model that immediately comes to mind when considering the more traditional trauma therapies (e.g., exposure therapy, EMDR, cognitive processing therapy, etc.), an approach currently being explored as a viable treatment for juveniles with multiple life stressors, Dialectical Behavioral Therapy (DBT), has shown promising results. DBT, originally developed by Marsha Linehan in the early 1980s for the treatment of female clients with suicidal and parasuicidal behaviors and symptoms consistent with Borderline Personality Disorder, has recently broadened its utility following ongoing research. DBT is a treatment based heavily on the behavioral therapy perspective with significant components steeped in dialectics (the give and take of the therapeutic interaction working to achieve the synthesis of opposites), mindfulness (non-judgmental acceptance of the present moment), and cognitive therapy.

DBT, based in the Biosocial Theory, conceptualizes the individual's presentation (potential trauma symptoms including interpersonal struggles and emotional dysregulation) as an end result of the combination of both biological (e.g., high sensitivity, high reactivity, and a slow return to baseline rates) and environmental (e.g., trauma, neglect, invalidation, etc.) factors. DBT is a model based on 4 stages. Having decreased the life-threatening, therapy-interfering, and quality of life interfering behaviors during the first stage, the second stage focuses on past experienced trauma and subsequent related symptomology. DBT utilizes both individual and group therapy modalities. It is during the individual therapy sessions that trauma focused techniques, such as exposure therapy and EMDR, are utilized to address presenting trauma or PTSD symptoms. DBT addresses trauma within a larger framework focused on utilizing mindfulness techniques to improve emotional regulation, interpersonal effectiveness, and decision-making abilities, which are practiced during the skills training groups. Upon successful reduction of trauma symptoms, additional DBT stages focus on achieving individualized goals towards wellness.

While research regarding the utility of DBT with the adolescent population is limited (no current studies based on the juvenile sex offender population), findings from a 12-week treatment study comparing DBT and treatment as usual (TAU) are promising (Rathus & Miller, 2002). Results of this

study indicated that 13% of the TAU subjects compared to 0% of the DBT subjects were hospitalized, 40% of TAU subjects compared to 62% of the DBT subjects completed treatment, and the DBT subjects demonstrated a more significant reduction of Axis I and Axis II symptomology post treatment. While DBT is currently not an empirically supported treatment for the adolescent population, perhaps with continued research, the full extent of the applicability of DBT for traumatized juvenile sexual offenders will be realized.



## The Adam Walsh Child Protection and Safety Act and the Juvenile Sex Offender: A Brief Update

BY: JENNIFER ERB CARAMENICO, M.A., L.P.C.

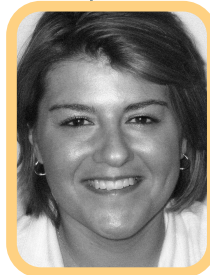
On July 2, 2008 the U.S. Attorney General through the S.M.A.R.T. Office disseminated the final federal guidelines for Title I of the Walsh Act: Sex Offender Registration and Notification Act (SORNA). Although the final guidelines for SORNA are similar to the original proposed guidelines; there have been some significant changes in these requirements as they pertain to juvenile sex offenders. The most important of these changes

include excluding the age of the victim as criteria for registration as well as narrowing the scope of applicable offenses pertaining to the juvenile offender. It appears that these changes came about as a result of commentary provided by professional stakeholders regarding the potential overwhelming impact on juvenile offenders. Under the proposed guidelines, many stakeholders were concerned that there would be a disproportionate inclusion of juvenile sex offenders.

As defined by SORNA § III(8), juvenile delinquency adjudications are considered convictions if the offender is prosecuted as an adult or the offender is 14 years of age or older at the time of the commission of the offense and the adjudicated offense is comparable to or more severe than the federal definition of aggravated sexual abuse (18 U.S.C. 2241) or is an attempt or conspiracy to commit such an offense.

To date the Commonwealth has not enacted any legislation implementing SORNA. However, in preparation for eventual implementation, the PA

JENNIFER ERB CARAMENICO



Juvenile Court Judges' Commission has recommended that jurisdictions begin to provide a colloquy to accused juveniles prior to accepting an admission in a sex offense case that meets the following criteria:

The juvenile was 14 years of age or older at the time of the commission of the offense

The offense committed has been charged as one of the following:

Rape (18 Pa. C.S. §3121)

Involuntary Deviate Sexual Intercourse (18 Pa. C.S. §3123)

Aggravated Indecent Assault (18 Pa. C.S. §3125)

Or any attempt or criminal conspiracy to commit any of these offenses.

This colloquy is the first of its kind in the Commonwealth. It outlines for offenders and parents the potential implications after adjudication of a specific sex offense. Because SORNA is retroactive it is important that families are aware of the eventual impact of such adjudications. Many juvenile sex offenders will be affected by this legislation upon its implementation by the Commonwealth. If the juvenile is on active supervision, in placement, or has reentered the system on a new charge when the Commonwealth implements legislation; he/she will be required to register as a Tier III sex offender.

To view the Colloquy in its entirety the reader is directed to Juvenile Court Judges' Commission website:  
[www.jcjc.state.pa.us](http://www.jcjc.state.pa.us) [www.jcjc.state.pa.us](http://www.jcjc.state.pa.us)



## Ravenhill

ROBERT YOCHUM  
M.S.W., L.S.W.



Ravenhill  
Psychological Services

Over the past two decades the sexual victimization of youth has become a top priority issue for policymakers, educators, service providers, academics and the criminal justice system. No longer considered a problem only of dysfunctional families, or a crime perpetrated by desperate lonely men who prey on children, accounts of sexual victimization of youth are as widespread as the diverse population it affects; and diverse responses have been implemented to combat this heinous social issue.

Ravenhill, a division of Edison Court, Inc., provides specialized case management and therapeutic services for at-risk juvenile populations including: adjudicated sexual offenders, sexually reactive youth and fire-setters, clients exhibiting serious mental health issues, as well as, victims of violent crimes and sexual abuse.

The community-based treatment provided by Ravenhill works with the client in an effort to maximize his/her social and individual potential. Specific therapeutic services provided are: psychiatric care, individual therapy, family therapy, group therapy, and family group decision making. Through appropriate collaboration and communication with referring agents, Ravenhill assists clients in the achievement of success and healthy living.

For more information please contact  
[ryochum@ravenhillservices.com](mailto:ryochum@ravenhillservices.com)



"...having attended over 70 trainings on various issues; this is the very best single two day training I have attended. EXCELLENT!"

— Conference Attendee

Close to 100 participants attended the recently held Edison Court Conference, A Multi-Systemic Approach to Healing Families: A Blueprint for Restorative Juvenile Sex Offender Management, on September 18th and 19th in State College, PA. This powerful conference presented the most up to date and innovative information available regarding the clinical treatment, supervision, and management of juvenile sexual offenders. The importance of collaboration and the pivotal and unique roles of the victim, family, and community in the healing process were the main focus. ECI CEO, Don Tangora, remarks, "in our 20 years of experience working with youthful offenders we have learned the importance of collaboration. This conference was meant in that spirit. We will make this an annual event!"

For information about upcoming conferences/trainings please visit [www.edisoncourt.com](http://www.edisoncourt.com)



WWW.

Change is Good!  
Same web address.  
Easier to navigate.  
More informative.  
Great new look.

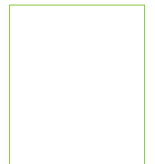
[www.edisoncourt.com](http://www.edisoncourt.com)

# Edison Court, Inc.

## Mathom House

350 S. Main Street, Unit 109, Doylestown, PA 18901

Analysis & Observations  
of the Issues Impacting  
Juvenile Justice  
TRAUMA | March 2009



@Issue: