SEX OFFENDER SPECIFIC TREATMENT WITH JUVENILES: CRITICAL COMPONENTS

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Juvenile sexual offenders are a unique and critical population in our struggle to end sexual abuse. A juvenile, any person less than 18 years of age, is a minor. Thus, there is a clear distinction legally and socially in how the system responds to them in contrast to adult sexual offenders. Juveniles are also clearly distinguishable from the adult population in that they are at the initial stage of psychobiological maturity. Although the normative age range for pubertal development is wide, only in rare cases does it occur outside the teen years. These two factors indicate the uniqueness of the population. The rationale for therapeutic intervention in this age group rests on a separate set of factors. One, there is evidence that many adult sexual offenders begin their offending pattern during the juvenile years (Davis & Leitenberg, 1987; O'Brien, 1982). Intervening in the beginning phase with such problematic behavior ensures a better prognosis. This is shown by, one, recidivism rates, with adult rates at about 20% while adolescent recidivism rates are reported at less than 10% (Davis and Leitenberg, 1987). Two, the number of victims is significantly reduced with early treatment.. Studies of adult offenders report an average of over 380 victims per offender, compared to an average of seven victims per adolescent offender (Arthur (ed.), 1988). Three, victims themselves can be reached and the risk of their developing inappropriate survival skills lowered. Adolescents who offend are reporting current rather than historical events. This allows for immediate evaluation, restitution and reconciliation for the victim. Successfully treating the juvenile sexual offender can have significant impact for ending sexual abuse.

Assumptions applied to the juvenile sexual offender often impede intervention. There is a prevailing myth that "boys will be boys" in relation to accusations of date rape, child molestation and non-touch offenses. The data now available suggests that waiting to see if a problem develops is a much greater risk than immediate evaluation with appropriate intervention. There are numerous risk assessment tools available through experienced clinical programs (e.g., University of Washington JSOP; Oregon State Report). The notion that juveniles are exploring their emerging sexuality is also, for the majority of cases, dubious. Patterns developed in adolescence continue into adulthood (Groth, Longo & McFadin, 1982; Abel, Mittleman & Becker, 1984). The traditional therapeutic approach of individually working through the psychodynamic origin of the problem is also a questionable assumption. Clinically, it appears that resolving "anger at mother", "distance from father", or other such trauma does little to impede the sexually abusive behavior of the adolescent offender (Lane & Zamora, 1985; Arthur (ed), 1988). Many of the juveniles sent to the Hennepin County Home School's residential program are referred when it is discovered they are continuing to offend while in traditional outpatient settings which do not directly address the sexually abusive behavior.

A comprehensive eclectic model serves best the many needs of the juvenile sexual offender. Sex offender specific treatment programs are composed of very specialized components in conjunction with techniques which are more widely applicable. There are significant similarities between programs which are best summarized in the Preliminary Report from the National Task Force on Juvenile Sexual Offending (Arthur, 1988). Although programs vary by theoretical emphasis, practical limitations and severity of client behavior/characteristics, there is consensus about essential areas to include in treatment. Denial and minimization of the offense, power/control needs of the offender, irrational thinking, impulse control, sexualization

of non-sexual needs, family dysfunction, compulsion and mood disorders are all considered necessary components for successful intervention.

One of the more salient aspects of the juvenile sexual offender as a client is that he is an involuntary client. The majority of adolescents who sexually abuse are male (Davis & Leitenberg, 1987); therefore the pronoun "he" will be used throughout this paper. Many overtly deny the offense, even after a trial, and all minimize what actually occurred. Whether there is denial or minimization, these youth attempt to avoid any professional intervention by stating they "do not have a problem", "it won't happen again", or any number of other rationalizations. The professional must assume the client is in fact guilty. It is the legal authorities who determine guilt or innocence, not the therapist. Given that, their denial does make sense. Who would readily admit to such behavior? There are understandable fears--fear of reprisal from many sources, destruction of one's self-image, or peer rejection. There may be mistrust--of adults, of authority or any meaningful attachment. There may be anger and depression leading to rebellion or hostility as a constant. It is essential that the youth reach the point where he takes full personal responsibility for his abusive behavior.

The juvenile sexual offender has a misunderstanding about the self in relation to others. Regardless of the origin of this misunderstanding, behaviorally it translates into using coercion or force to achieve his wants. Clinically, this is seen as a power or control issue, where the client cannot tolerate a risk of rejection. Therefore, he ensures success through manipulation, coercion or force. This dynamic can be seen in the range of sexual offenses, from non-touch (exposure, obscene phone calls) to rape with a weapon. This dynamic is seen as an actual sense of helplessness which must be replaced by a sense of personal adequacy.

Irrational thinking is another predominating characteristic of the juvenile sex offender. From simplistic excuses, such as "She wanted me to do it" to complex rationalizations, the youth uses these thoughts to accommodate their abusive behavior. These youth are reactive rather than proactive, and thus consistently project blame onto others. Constant vigilance on their thought patterns, with practice using corrected thinking enables the offender to take personal responsibility for their own behavior. The clinical literature refers to this area in terms of irrational thinking, cognitive distortions or thinking errors, depending on the theoretical background of the clinician. Whatever the theoretical orientation, the goal is for thought patterns to reflect "ownership" of behavior.

The sexualization of non-sexual needs is a major issue with the majority of juvenile sexual offenders. There is a minority of cases where the issue may be one of sexual preference (pedophilia). More typically, there is a wide range of emotional and social needs that fail to be met by deviant sexual behavior. These include a sense of attachment, peer acceptence, nurturance, self-empowerment or individuation, pleasure and a sense of intimacy. For some youth many of these needs are part of their offending behavior, for others, only one may be the relevant factor. Provision of these "missing pieces" by replacing the deviant behavior with age appropriate and socially acceptable behavior greatly lowers the risk of reoffending.

Compulsivity is an area which must always be considered. The sexual offending pattern may not yet be compulsive, but due to the "sedative" effects of sexual pleasure, they can easily become so. The adolescent who has transferred early self-stimulating behavior such as thumb sucking or rocking into the sexual realm is at high risk to develop compulsive deviant sexual patterns. The adolescent who offends solely for "good times" is compulsive. It is possible to provide alternative behaviors, monitoring systems or to remove the meaning of the behavior depending on one's theoretical base or preferred treatment modality.

In early adolescence (12-15 years), impulse control is seen as a central issue. These youth may be attention deficit disordered, they may believe they are not able to control their behavior, or they may believe in sexual myths which lead them to seek immediate gratification. Education about sexuality, exercises in delay of gratification and medication are all avenues which are used to develop impulse control. Adolescents for whom impulse control is a primary issue will also behave in likewise fashion outside of the sexual, causing disruptions at home and at school.

Since the adolescent's home environment is almost always available, dysfunctional patterns of family functioning can be identified. Systems theory has had a significant impact on our ability to understand and thus treat the sex offender. Often, the troubled youth is the healthiest family member, and attempts at intervening in the family system are met with resistance. Here, in the field of sexual abuse, the notion of the "identified patient" is taken to extremes, often to hide generations of abuse, neglect and distorted family relationships. In some cases, the best outcome can only be achieved by permanent removal of the youth from the family of origin.

Lastly, the presence of an exacerbating mood disorder needs to be considered. Although psychiatric problems do not appear to predominate in this population (Kavoussi, Kaplan & Becker, 1988), mood disorders greatly impede therapeutic progress. Within the Hennepin County Home School program, about a third of the residents are diagnosed with either a major depressive or bipolar mood disorder. The use of medication to treat these disorders has, over the past three years, proven a positive adjunct to the treatment program. It appears to reduce the length of time in residence two to four months in what is typically a 12-14 month program. The future of dual diagnosis with this population rests on research using comparison groups and follow-up studies.

The eight characteristics reviewed are considered the major areas which must be addressed to successfully treat the juvenile sexual offender. How are they addressed? Techniques which: 1) Enhance personal accountability, 2) Aid the youth in defining their sexual assault cycle with interventions, 3) Produce an accurate life history, 4) Develop a prosocial sexual identity, 5) Teach assertive behavior, and 6) Provide victim reconciliation address those areas directly in relation to the sexual offense. The sexual assault cycle and victim reconciliation will be described in detail as critical components in sex offender specific treatment. The sexual assault cycle covers many of the essential areas of treatment. Sexual assault cycle interventions clarify many of the other components of treatment. Victim reconciliation reflects not only treatment of the offender, it also reflects our philosophy behind treatment for the offender. That is, victim identification and treatment, and prevention of victimization.

The sexual assault cycle includes the youth's feelings, thoughts and behavior before, during and after the offense. This cycle is also referred to as a rape cycle (Lane & Zamora, 1985), an offense syndrome (Knopp, 1985) or more generally a cycle of abuse. Within the field, the defining characteristics are equivalent regardless of the referrant term. Typically, this assault cycle is defined individually by each youth. A general theoretical cycle is suggested by Ryan and colleagues Lane, Davis & Isaac (1987). Research into the applicability of a generalized cycle might provide useful data into the similarities and differences within this population. However, given the high risk nature of this population, a cycle defined by each individual's experience is more expedient for treatment purposes. Individual definition allows for total ownership of the assault cycle as well as interventions that can effectively break the cycle for that individual.

The sexual assault cycle provides an understanding of how the youth gives himself permission to hurt others, how the victim is

selected, and identifies what must change to develop a non-abusive lifestyle. The Preliminary Report from the National Task Force on Juvenile Sexual Offending states that "the sexual assault cycle is used as a frameqork to understand the interrelationship of situations, thoughts, feelings, and behaviors which lead up to and follow a sexual assault. The situations which trigger the cycle are identified in order to recognize risk and avoid or react differently; the thinking errors are corrected; feelings are accurately labeled and alternate methods of nonexploitive expression are explored; and behavioral methods such as covert sensitization are used to counter fantasy and planning." (p33)

The client begins work on his sexual assault cycle early in the treatment process continuing until full comprehension is reached. This enables the client in many ways to be "in charge" of his treatment program. Issues such as peer or family relations, early abuse or neglect, misplaced blame, irrational thinking, etc., become clear as the sexual assault cycle becomes more specific and complete

The sexual assault cycle goes through the following process of formation: Initially, the client may be unable or unwilling to discuss his/her cycle of assault. The unable client usually shows significant memory deficits, confusion or extremely high levels of anxiety when the subject is broached. The unwilling clients act as if their adjudicated offenses are the only abusive behavior in their entire life history, claiming there is no "cycle", or maintain that "it was a mistake" or that it was not a sexual assault. Even though the youth may be forming relationships in the program and admitting (albeit without remorse) to his commitment offense, beginning the process where he knows the going will get tough creates regression or resistance.

Jerry, a bright, sociable 16 year-old who began serious work on why he raped in terms of his single commitment offense, panicked

when asked to look across his life history for similar events. Jerry had encapsulated that one offence and separated it out of his self-image.

Bob, on the other hand, with 74 identified preschool victims, literally could not identify initially when he started his assault cycle or who his first victim was. His mental confusion was his major defense against his own behavior.

The sexual assault cycle work begins by requesting the youth to write up each of their offenses separately, starting with the earliest occurrence and going to the most recent. The cycle timeline, which includes the precipitating event through the assault and following it, varies widely from individual to individual. When these separate assaults are written up, similarities across the events are noted and a rough assault cycle is available. These first attempts are incomplete and superficial, but provide many clues as to the relevant issues which need to be raised. For example, Bob's first cycle went as follows:

1. I got a job as Sunday School teacher's helper.
2. I liked being with the children.
3. I would take the children to the bathroom.
4. I got sexually aroused.
5. I made them let me have sex with them.
6. I was scared of getting caught.
7. I threatened them.
8. I took them back to class.

Why did Bob get this job? What got him sexually aroused taking preschoolers to the bathroom? For Bob, it took eight months to finally begin to answer these questions.

The clues provided by first attempts at defining one's assault cycle are a starting place for identifying the problems these youth deperately avoid. Since no one but the youth know what the problems are, the information must come from them. The assault

cycle is refined by getting the client to expand on each step. This expansion includes defining the situation(s), identifying specific feelings, defining specific behaviors and recalling the thoughts that occurred at that time.

Let's go back to Bob. His first attempt actually looks good. Why go any further? Taking anything at "face value" in this business usually means the core of the sexual offending will remain a secret, leaving the offender untreated and at high risk to reoffend. Why did Bob get this job? "I like teaching children." "My family is very active in church." "I wanted to do something useful." These are all what I will call first order responses. Acceptable perhaps as part of a conversation with a healthy adolescent, but highly questionable with our population. How did Bob know he "liked children" or "likes teaching children"? Bob had made friends with the three-year old daughter of his mother's boy friend when he was 10 years old. What did Bob find sexually arousing in taking preschoolers to the bathroom? As it turns out, nothing. He took them to the bathroom in order to be sexual with them. He had learned to find sexual pleasure in young children with that first "friend" of his, and when she and her father moved away, went looking for opportunities elsewhere.

There was no information anywhere about that first victim and Bob had chosen to keep it a secret. Talking about this first victim meant talking about his life issues in relation to his offending: the death of his father, emotional abandonment by his mother, his own depression and social isolation, jealousy and fear of failure. That first "relationship" seemed to meet so many of his needs: a desire for care and attention without threat of rejection or abuse, a desire for revenge against his mother and her boy friend, a wish for things to "just be there for him". And, he could wrap the whole responsibility for her on the adults because they made him babysit her so they could be alone together.

Bob worked on this assault cycle:

1. I would usually feel bored.
2. Jim and Ann could come over to the house.
3. I would feel jealous and think about how unfair things were.
4. Then I got mad at my Mom.
5. Ann cheered me up
6. We played together.
7. I would pretend we were the adults.
8. I would start to touch her.
9. I fantasized about being sexual with a girl my age.
10. I would act out the fantasy with her.
11. We played different regular games.
12. I felt happy and relaxed.

As time went on in this relationship, Bob pretended less often that they were adults, and fantasized more about Ann herself rather than a same-age peer. When she and her family moved, he reacted with intense grief and rage. This put him right into his cycle, and he had to find solace through sexual contact with a child in an opportunistic fashion. As the hidden maze of Bob's experience emerged, the nature of his sexual deviancy became understandable. Bob, at 15, had a compulsive behavior pattern that protected him. He planned on getting the job at his church's Sunday School because of the opportunity it provided him on a regular basis to seek sexual relief with children. He knew how to use God as a threat, and knew that his would be an authoritative position. His final assault cycle:

1. Any negative feelings.
2. Fantasize about sex with a child.
3. Remember he would have the opportunity to be sexual with children.
4. Feel relief.

The sexual assault cycle is complete when it provides full comprehension to the offender about why he rapes. Many interventions occur on this journey. In Bob's case, psychiatric treatment

for depression, family therapy to resolve and restructure early experiences, and learning to directly address problems in the residence all helped to undermine this cycle. Without access to children to reinforce his fantasies, he began to recognize that his preferred fantasy for self-pleasure was a post-pubertal female. Bob developed a set of practical interventions to break this cycle outside of the residential setting. He learned a checklist of symptoms of depression and found a psychiatric resource in the community he was moving to. He joined an outpatient support group as he knew he needed time to develop good friendships in a new community. He chose a vocation which did not involve any access to children. In defining his sexual assault cycle, Bob was able to work through 1) the historical basis of his offending, 2) practice new skills in the present, and 3) develop a healthy plan for the future. In order to succeed in this task, Bob had to directly face and 4) take responsibility for his sexually abusive behavior. These four elements are essential to eliminate sexually abusive behavior.

Victim reconciliation is the second critical treatment component. Empathy is the human emotion which prevents abuse. Learning to emphathize, or "put yourself in someone else's shoes" is a part of the social maturation process. It is also difficult to teach as our society is rife with examples of unempathetic behavior. Victim reconciliation can teach at least limited empathy, that is empathy for "my sexual abuse victim". Victim reconciliation involves two processes. One is the development of empathy toward the victim through describing their position. The second is reparation which reinforces empathy and personal accountability through apology and restitution.

The development of empathy begins as accurate interventions in the sexual assault cycle take place. The majority of our clients are emotionally distanced from themselves. Thus, they are also unable to comprehend others' emotional states. When they begin to reexperience the feelings that occur during their sexual assault cycle without being able to continue with the cycle, they are

beginning to reintegrate their emotional self. The client then begins to work on providing a description of his victim's position. This includes what the victim said, how s/he felt and how s/he behaved from the first point of contact through the assault. We are aided in this process by contact with the victim, the victim's family and therapist. Contact is made through appropriate channels, in the hope of healing both victim and offender. Information from the victim helps us guide the offender into a realistic portrayal of his victim's position.

Let us return to Bob here. His church was able and willing to provide education and counseling for many of the families he victimized. The church, with permission from the families, collected the stories and aftermath effects of the sexual abuse. For example, one mom whose three and a half-year old son was abused for almost a year, took dictation from Dan as part of his healing process. She provided copies to the pastor who sent it to us. "Bob really hurt me and I'm about to kill him...Mom should call the police lots just in case he can unlock the jail himself and get out and I hope if he gets out he won't hurt me..." are just a few of the lines he told his Mom night after night as he worked through his pain and fear. The direct information from victims gives us what we need to work with each youth. The range of reactions in victims during a sexual assault is great, and dependent on many factors. Talking with these offenders about what might have happened is ineffective; defenses are raised and there is no check on the accuracy of their portrayal.

When the youth is able to honestly portray the victim's position, work begins on apologies. These are preferably done in face-to-face interviews. However, direct apology is not always viable, due to the age of the victim or the victim's desire to maintain an absolute distance from the offender. When this is the case, apologies are rehearsed and played out within the program. The youth must learn to accept without rancor his victim's unwillingness to hear an apology. In Bob's case, although many

families accepted apology letters from him to share and save for their children, many did not. In fact, Bob was unable to return to his home community due to threats to his safety. Instead of testing this situation, Bob chose to go to school far away from his home community and begin a healthy life for himself in a new community. Which is a better response, forgiveness or retaliation? Perhaps little Dan can answer that for us. "Every night and every day I want to write about Bob. He was so mean. I want to talk about Bob. I want to give my letter to Bob cuz he was mean to me... Maybe the police will take me there to talk to Bob and give him a letter. Bob would say to me I'm sorry for hurting your feelings."

In instances where face-to-face reconciliation sessions take place, the process of healing for both offender and victim can be seen. Tim, a 13-year old who committed a "date rape", was extremely fearful about his victim's possible anger at him. His victim, 12-year old Ellen, felt exactly the same way! Although "sure" Tim would be mean and hurtful, Ellen wanted to know "what he's gonna be like". With consent from her mother, Ellen met with Tim to hear his apology. He told her he knew he forced her to have sex with him and that was wrong. He expressed his fear of her anger but said she had the right to feel that way. He admitted to feeling angry that she turned him in, but that he had given her no other way to stand up for herself. Ellen asked him to repeat what he said twice, listening quietly the whole time. Tim talked to her about seeing her side of the story, that she felt peer pressure, had really liked him and didn't want to struggle with him. Ellen was able to see the positive result of her own assertive action, and Tim was able to face his own behavior and grow beyond it.

Rituals mark important moments in life. The ritual of the victim reconciliation process marks the point at which the young offender begins a more positive lifestyle. He faces directly his old behavior, he defies his own survival skills and he practices

an essential new life skill. A final word of caution about this process is necessary, and that is that the utmost care must be taken that the victim is "willing and able" to handle reconciliation and that the offender is truly able to present the victim's perspective. Again, I will quote from the National Task Force: "Victim and offender therapists must each assess their client's readiness, expectations, and safety in such sessions, and it should be a voluntary component." (p44)

The Hennepin County Home School's program for juvenile sexual offenders is seven years old. In that time, approximately 250 young men have completed the treatment program. Our program definition comes from our clinical experience. There are no accurate statistics comparing individual treatment plans with follow-up measures of success. There are no comparison studies with different types of programs. It is important for this information to be gathered and used to verify or discredit particular aspects of programming. Until that time, however, we must continue to do what we can to stop sexual abuse by stopping abusers. Although our recidivism rates are based solely on getting caught again, this data is encouraging. Over the years, our recidivism rate fluctuates between 3% and 7%. Many of our clients stay in touch with us, giving us some further basis for hope for their future. And Bob is at school, working part-time, attending his support group and dating. He is not sexually abusing children.

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SEXUAL ABUSE TREATMENT CONSULTANCY:

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Major area of expertise: Male juvenile sex offenders

Experience with:
- Adult sex offenders, incestuous and extrafamilial
- Adolescent female offenders
- Child and adolescent victims
- Adult victims, male and female

Eight years direct clinical experience with these populations and with program development.
Four years experience with program administration.

Six years experience providing workshops and presentations in the sexual abuse field.

Training workshops or presentations can be tailored to the specific needs of the organization requesting the training. This training is provided under the auspices of the Hennepin County Home School. Fees are used to provide training opportunities to the staff of the County Home School. On-site training at the facility is also available, with fees dependent on number of participants and length of stay at the facility.

Unaffiliated off-site training is available on a limited basis.

An on-site fee schedule is avaliable upon request.

Off-site fee are arranged on an individual basis dependent on length of stay and distance (travel time).

Enclosed is a resumé and recent presentations.

Thank you for your interest, please feel free to call with any inquiries!

RESUME

Janis F. Bremer, Ph.D.

8/19/85-current — Program Director, Juvenile Sexual Offenders Program
Hennepin County Home School

This is a 48 bed correctional residential treatment program. There are 2 correctional supervisors, 6 social workers, 18 child care workers and a psychiatric consultant. The program includes individual, group and family therapy in a 24 hr. therapeutic milieu. Residents are 13-18 yr. olds adjudicated on a sexual offense.

6/85-current — Project Member: Sexual Health and Responsibility Program: An Adolescent Perpetrator Prevention Program.

This is a prevention program for 12 - 15 yr. olds developed by a seven member team under the auspices of the Minnesota Department of Human Resources.

1/84-8/85 — Director, SEASONS Juvenile Offenders Program
Program in Human Sexuality
Department of Family Practice and Community Health
University of Minnesota Medical School

This is a coeducational outpatient program for adolescent sexual offenders. Responsibilities included individual, group and family therapy. Responsibilities also included cofacilitating two adult sexual offender groups and providing training to students.

7/81-1/84 — Child Development Specialist, PHASE
East Communities Family Center

The Program for Healthy Adolescent Sexual Expression is an outpatient program for adolescent sexual offenders. Responsibilities included developing and running a 30 day evaluation, cofacilitating group and family therapy and individual therapy.

8/80-11/82 — Child Development Specialist, Breaking the Cycle
Christopher St., Inc.

Breaking the Cycle was a program developed under a McKnight Foundation grant to work with families in which the parents had been abused as children.

7/80-7/81 Post-doctoral Fellow, Adolescent Health Program
Health Care Psychology
University of Minnesota Medical School

10/75-9/79 Doctoral student, Ph.D. in Developmental Psychology
University of Leeds
Psychology Department
Leeds, England

Member: American Psychological Association

Member: American Association of Sexuality Educators, Counselors and Therapists

Member: C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect: Adolescent Perpetrators Network

Member: Advisory Board for the National Task Force for the Creation of Standards for the Assessment and Treament of Juvenile Sex Offenders

Member: Coalition of Adolescent Sexuality Therapists, Minnesota

WORKSHOP and CONFERENCE PRESENTATION EXPERIENCE HIGHLIGHTS

Janis F. Bremer, Ph.D.

1988 Oct. 2-5 Second National Treatment Training Conference : Juvenile Sexual Abusers, Georgia State University, Atlanta, GA
* Program Chairperson
Workshop : Family Therapy - Advanced Casework
Workshop : Secondary Dynamics of the Residential Setting

1988 Jul.19-21 Initial Effects and Long Term Outcome of Child Abuse and Neglect : Breaking the Cycle, University of Leeds, Leeds England.
Sex Offender Specific Treatment with Juveniles: Critical Components

1988 May 4-6 Minnesota Psychological Association Annual Meeting: Education, Research, and Application: An Update, Minneapolis, MN
Adolescent Sex Offenders: Issues and Treatment

1988 Feb 29-Mar 4 The Jamaica Institute on Victims/Victimizers: Intervening on the Cycle of Abuse, Runaway Bay, Jamaica
Violent Intimacy: A Developmental Model for Treating Victimizers

1987 Dec 4 Hennepin County Medical Center Psychiatric Department, Minneapolis, MN
Treatment of Juvenile Sexual Offenders

1987 May 22-24 Third National Adolescent Perpetrator Network Meeting, Keystone, CO
Workshop: Application of Theory: Family Systems Therapy

1987 Apr 30-May 2 Adolescent Sex Offenders Conference, Columbus, OH
Presentation: The Hennepin County Home School Program

1987 Apr 4-6 Sexual Health and Responsibility Program: An Adolescent Perpetrator Prevention Program, Brainerd, MN
Teacher Training Workshop

1986 Sept 26-7 8th Annual Adolescent Medicine and Health Care Conference: High Risk Youth, University of Minnesota, Minneapolis, MN
Workshop: Treating the Adolescent Sexual Offender

1986 Jun 2-3 Treatment of Families in Sexual Crisis: Program in Human Sexuality, Medical School, University of Minnesota
Assessment of Adolescent Victims and Perpetrators

1986 Apr 27-30 First National Treatment Training Conference: Juvenile Sexual Abusers, University of Minnesota, Minneapolis, MN
* Program Committee
General Session: Impact of Sexual Abuse on the Developmental Progression
Workshop: Evaluation of Female Perpetrators