

Challenging Traditional Paradigms: Applying the Trauma Outcome Process (TOPA) Model¹ In Treating Sexually Abusive Youth Who Have Histories of Abusive Trauma

Lucinda A. Rasmussen, PhD, LCSW
San Diego State University
School of Social Work

Treatment approaches widely utilized over the past 20 years to intervene with sexually abusive youth have traditionally followed the paradigm of “sex offender specific” cognitive-behavioral therapy (CBT-SOS). Taken from the world of adult sex offender treatment and typically implemented in a group treatment setting, the primary goal of CBT-SOS is to increase the youth’s accountability for sexually abusive behavior. Therapists who utilize this model are often quite confrontational, compelling sexually abusive youth to admit to the details of their sex offenses (as documented in police reports and other official records). Polygraph testing is often used in tandem with CBT-SOS to motivate full disclosure, especially for those youth who state they did not commit the alleged offenses. Often such youth are viewed as being “in denial” and may be excluded from treatment groups until they begin to admit their offenses or their polygraph tests are determined to be “non-deceptive.” Progress in CBT-SOS groups is typically predicated on sexually abusive youth explaining in great detail the “Sexual Abuse Cycle” assumed to be associated with their sexual offending behavior (i.e., triggers for offending, thinking errors, sexual fantasies, methods used to manipulate and/or coerce the victims) (Lane, 1997; Lundrigan, 2001). Discharge from treatment is usually contingent on youth developing a detailed “relapse prevention plan” describing specific strategies they plan to use in order cope effectively with stressors, avoid “high risk situations” and avoid recurrence of sexually abusive behavior (Gray & Pithers, 1993; Steen, 1993).

CBT-SOS, with its various concepts (e.g., thinking errors, Sexual Abuse Cycle, relapse prevention), has been touted over the years as the gold standard for treating youth who offend sexually (Becker & Kaplan, 1993; Gray & Pithers, 1993; Lundrigan, 2001; National Task Force on Juvenile Sexual Offending, 1993; Ryan & Lane, 1997; San Diego County Sex Offender Management Council, 2003). Nationwide surveys have found that the majority of treatment programs for sexually abusive youth routinely utilize CBT-SOS as their chief mode of practice (Burton & Smith-Darden, 2001). Commonly used CBT-SOS interventions include: (a) cognitive restructuring (to address cognitive distortions); (b) covert sensitization (to recondition deviant sexual arousal); (c) social skills training (e.g., to improve anger management and increase assertiveness) and psychosexual education (e.g., to teach healthy sexuality) (Becker and Kaplan, 1993; Gray & Pithers, 1993; Lundrigan, 2001). Despite its wide usage, reviews of the research have found little empirical support for using CBT-SOS groups with youth (Becker, 1998; Chaffin & Bonner, 1998; Chaffin, Letourneau, & Silovsky, 2002; Righthand & Welch, 2001; Swenson, Henggeler, & Schwoenwald, 1998; C. Venziano & L. Venziano, 2003; Weinrott, 1996).

The traditional model of CBT-SOS is now being challenged by new, holistic, and strength-based paradigms (e.g., see Prescott & Longo, 2006). Some have noted that CBT-SOS is so narrowly focused on risk management that it fails to teach youth “how to live healthy lifestyles” (Simons, 2007, p. 82). Others have pointed out that this model is a prime example of the “trickle down phenomenon” (Prescott & Longo, 2006) whereby confrontational, forensically based interventions designed for adults (e.g., polygraph testing, arousal reconditioning) are widely applied to youth, ignoring the developmental differences that set youth apart from adults (Chaffin & Bonner, 1998; Chaffin, Letourneau, & Silovsky, 2002; Longo & Prescott, 2006; Rasmussen & Miccio-Fonseca, 2007a; 2007b; Righthand & Welch, 2004). Unlike adults, sexually abusive youth are still malleable and open to protective influences as they mature emotionally, cognitively, and behaviorally; their developmental trajectory is as yet unknown. Assessment findings are questionable and invalid when youth are assessed and treated as if they were adults (Miccio-Fonseca & Rasmussen, 2006; Rasmussen & Miccio-Fonseca, 2007a; 2007b).

Rather than being uniformly helpful, CBT-NOS group treatment may have adverse effects on some youth. When groups are comprised of members with offenses of varying severity, lower risk youth are exposed to negative influences from high risk, delinquent peers (Chamberlain & Reid, 1998, as cited by Chaffin et al., 2002).

Requiring sexually abusive youth to disclose their sex offenses to a group of peers (a common treatment requirement) exposes them to the graphic details of each other's offenses and puts them at risk to learn new and more elaborate ways to offend sexually. At times, interventions may backfire, creating negative norms in the group. For example, Chaffin and Bonner (1998) reported knowing youthful offenders who confessed in groups to sex offenses they did not commit or fabricated deviant sexual fantasies they did not have, in order to perhaps fit in with other youth in the group, comply with treatment plan expectations, and assure their therapists they were making treatment progress.

Ethical dilemmas permeate the use of the CBT-SOS approach with youth, especially when implemented in tandem with polygraph testing. The polygraph is a well established utility tool and a valued component in evaluations of adult sex offenders. Increasingly used with sexually abusive youth, it is often mandated as a necessary component of treatment (see: San Diego County Sex Offender Management Council, 2003; Colorado Sex Offender Management Board, 2003 [Section 7.120, pp. 99-100]; Utah Department of Human Services – Juvenile Justice Services [DHS-JJS], 2005). Proponents of polygraph testing claim it breaks through patterns of secrecy and denial that often characterize sexually abusive youth (Janes, 1993), facilitating the youth's disclosure of abusive behavior and aiding treatment. Nevertheless, there are several concerns that make polygraph testing questionable when used with youth. First, polygraph examiners are not required to have specialized education and/or training or qualifications related to specific developmental age groups (e.g., working with children, adolescents, developmentally delayed or the physically handicapped) (American Polygraph Association, 2004a, 2004b; Center for Sex Offender Management, 1999). Some states even fail to specify a lower age limit for polygraph testing, meaning that completed on children under 12 who are sexually abusive or have sexual behavior problems might be given a polygraph exam (Utah DHS-JJS, 2005). There are no norms for polygraph testing for youth, calling into question findings that state that a youth is “non-deceptive” or “deceptive.” Also, polygraph testing often presumes guilt, dismissing the self-report of youth who claim that they did not commit the offense, but may in fact be telling the truth. Finally, polygraph testing may provoke anxiety and create additional trauma in youth who already have a high level of physiological arousal due to the impact of prior traumatic experiences (e.g., physical abuse, sexual abuse, witnessing domestic violence).

Although the immediate and long-term effects of polygraph testing on previously traumatized youth are unknown, it goes without saying that the experience of taking a polygraph is likely to be stressful for a youngster and provoke significant anxiety. When coupled with chronic feelings of powerlessness that led the youth to sexually offend, this anxiety may contribute to continued behavior problems, and increase the youth's risk for reoffense. Nevertheless, some treatment programs have had good results in using the polygraph to obtain disclosures. Clinicians in these programs report that anxiety about taking a polygraph test has motivated youth in their programs to reveal their sex offenses, while “failing the polygraph” has spurred other youth into becoming more accountable and forthcoming. In fact, youth in these programs have been known to express relief that they are finally able to disclose their sex offenses (M.H. Fredericks and Teen Triumph Residential Center Clinical Staff, personal communication, May 29, 2007). Despite this conventional clinical practice wisdom, however, there is limited empirical evidence to suggest that polygraph testing is effective with youth (Hunter & Lexier, 1998).

When sexually abusive youth are compelled by such methods as polygraph testing and CBT-SOS groups to be accountable, they are not likely to willingly engage in treatment (Marshall, 2007; Prescott, 2007). Certainly, such confrontational approaches are counterintuitive for motivating behavioral change. Although youth may appear on the surface to be cooperative and will discuss their sex offenses (and Sexual Abuse Cycle) openly in the group treatment, their efforts may be superficial and insincere. Some youth comply with treatment not because they are motivated, but out of fear. For example, sexually abusive youth may disclose details about their offenses during polygraph testing in an attempt to avoid incurring restrictions that may be imposed by their treatment program, should their polygraph results be determined to be “deceptive.” Observed changes in the youth's behavior may be elusive and short lived.

CBT-SOS interventions (and the polygraph) are typically applied in a “one-size-fits-all” fashion, often without regard for differences related to history of trauma, culture, family history and dynamics, gender, developmental capacities, learning style or other factors (Chaffin et al., 2002; Hunter, 2006; Longo, 2004; Weinrott, 1996).

Structured CBT-SOS treatment exercises are presented through didactic methods. Verbally oriented teaching methods ignore the different learning styles and treatment needs of youth who have attention problems, auditory processing disorders, sensory impairments, or are developmentally delayed (Longo, 2004). The confrontational CBT-SOS approach myopically focuses on the youth's sexually abusive behavior and places little, if any emphasis on identifying contributing problems (e.g., prior victimization, disrupted attachment, growing up in a chaotic, abusive, and/or invalidating family environment; exposure to violence in the community). Effects of the youth's own victimization and previous traumas are addressed only minimally in CBT-SOS treatment, if at all (Lundrigan, 2001; Prescott & Longo, 2006). CBT-SOS programs that do focus on the youth's own trauma often wait to do so until later stages in treatment. Delays can be harmful to the well being of sexually abusive youth, who often only make treatment gains through revealing childhood experiences and "are first able to access and acknowledge the feeling of vulnerability and helplessness" (Ryan & Lane, 1997, p. 275).

The emerging strengths based treatment paradigms assume that skillful interviewing by professionals with expertise in treating sexually abusive youth will be more effective in motivating these youth to be accountable than the polygraph or CBT-SOS. When youth are engaged in treatment through a client centered approach that is neither confrontational or shaming (Jenkins, 2006; Marshall, 2007), but "warm, empathic, rewarding, and directive" (Prescott & Longo, 2006, p. 55), they are much more likely to sincerely take responsibility for their offenses, commit to the treatment process, and maintain the treatment gains achieved.

The Trauma Outcome Process Assessment or *TOPA* model (Rasmussen, 2006, 2007) exemplifies the new, strengths based paradigm. The *TOPA* model holistically considers the youth's sexually abusive behavior in the multidimensional, ecological context of his or her neuropsychological functioning, family history and dynamics, trauma history, and community context. Conceptualized and introduced to the field of treatment for sexually abusive youth more than a decade ago (Rasmussen, 1989; Rasmussen, Burton, & Christopherson, 1990, 1992), the Trauma Outcome Process was later formalized as an integrative practice model (Rasmussen, 1999, 2001, 2004) and recently updated and re-named the *TOPA* model (Rasmussen, 2006, 2007). Unlike the traditional model of CBT-SOS, the *TOPA* model is not drawn from adult paradigms, but was developed as a framework for understanding children and adolescents who are sexually abusive, and/or have been sexually abused (Rasmussen et al., 1990, 1992). The *TOPA* model is comprehensive and culturally and developmentally sensitive. Interventions, tailored to the individual youth, help the professional to identify and harness "protective influences" (Katz, 1997) on behalf of the youth. The *TOPA* model "connects the dots;" it assesses how the youth's sexually abusive (and self-destructive) behaviors and current stressors relate to historical factors of prior traumatization, disrupted attachment with significant caregivers, and growing up in a chaotic environment.

Interventions utilizing the *TOPA* model are directed toward helping sexually abusive youth to: (a) increase their self-awareness (of thoughts, feelings, body sensations, motivations, and actions) (Burton, Rasmussen, Bradshaw, Christopherson, & Huke, 1998; Miller, Nunnally, and Walkman, 1975; Rasmussen, 1999; Rasmussen et al., 1990, 1992); and (b) recognize how their sexually abusive behavior is connected to their emotional and cognitive responses to past traumatic experiences. Creating safety is a prime concern; the professional uses careful and empathic interviewing to gather information and build a strong therapeutic alliance with the youth (Rasmussen, 2001; 2002a). Researchers evaluating treatment programs for sexually abusive youth have affirmed that "warm, empathic, encouraging, directive, non-confrontational characteristics of therapists were associated with treatment benefits" (Levinson & Prescott, 2007, p. 129), including reducing denial and minimization (Marshall, 2005).

TOPA model interventions blend expressive therapeutic modalities (e.g., art therapy, bibliotherapy, sand tray therapy, puppets and dolls, role plays and psychodrama) with positive and non-confrontational CBT-oriented techniques (Rasmussen, 2001, 2002a, 2006; Rasmussen & Cunningham, 1995). This integrative approach is sensitive to the cultural background and developmental capacities of each youth, including youth with visual or kinesthetic learning styles and/or those who may have attention deficits, auditory processing disorders, or sensory impairments. It is especially beneficial for these youth, as it allows them to explore their thoughts and feelings about their past traumatic experiences and current sexually abusive behavior in nonverbal, experiential ways (Longo, 2004).

The paradigm guiding the Trauma Outcome Process Assessment describes three separate and distinct behavioral pathways that youth might take in response to a traumatic (e.g., sexual abuse): (a) internalized, self-destructive behavior resulting in harm to self (Self-victimization); (b) externalized, abusive behavior resulting in harm to others (Abuse); and (c) adaptive behavior that enables the youth to resolve and integrate traumatic experiences within the context of their other life experiences (Recovery/Integration). These responses are not linear or cyclical; they are systemic “processes” that are experienced during different times subsequent to experiencing a traumatic experience (either a one time event, or abuse occurring over a long period of time) (Rasmussen, 1999; Rasmussen et al., 1992). The youth’s responses in the Trauma Outcome Process are influenced by their self-perceptions and their ability to regulate affect and behavior (Friedrich, 2002; Rasmussen, 2001). Both are largely dependent on the quality of the youth’s attachment to parents or significant others (Friedrich, 2002; Rich, 2006).

The Trauma Outcome Process can be triggered by either a traumatic experience or a benign, innocuous event that, for whatever reason, provokes thoughts and feelings in the youth associated with or reminiscent of a past trauma. “Trauma” is defined broadly in the *TOPA* model as “sudden, unexpected and nonnormative experiences that exceed individuals’ perceived coping strategies and disrupt their frame of reference, psychological needs, and related schemas” (McCann & Pearlman, 1990, p. 10, as cited in Rasmussen, 2001, p. 10). This covers a wide range of abusive experiences (e.g., sexual abuse, physical abuse, emotional abuse, severe neglect or abandonment, witnessing domestic violence, exposure to community violence, war, or terrorism) (Boyd & Rasmussen, 2005; Rasmussen, 1998, 2002b; Miccio-Fonseca, Rasmussen, & Fredericks, 2005), as well as other traumatic experiences that typically provoke feelings of powerlessness (e.g., receiving a diagnosis of serious illness and/or disability; experiencing the aftermath of a serious accident; surviving a natural disaster) (Rasmussen, 2006).

Distorted thinking processes are evident in both the Abuse and Self-victimization responses in the Trauma Outcome Process. They include “trauma echoes” (Gray, 1989), (i.e., thinking processes that are linked to memories and feelings associated with the youth’s prior traumatic experiences). Youth engaging in the Self-Victimization and Abuse responses have inaccurate self-perceptions acquired from how they have been treated by significant people in their lives. These self-perceptions influence how they respond and relate to others and how they protect themselves. Denial, minimization, and blame are common thinking patterns in both the Self-Victimization and Abuse responses.

Self-victimizing youth manifest “internalized thinking errors,” that is, they often take on excessive responsibility and blame themselves for things that are not their fault and for which others should be responsible and accountable (Rasmussen, 2007). They have poor self-regulation; the triggers in their Trauma Outcome Process may provoke them to engage in various self-destructive behaviors (e.g., suicidal gestures, “cutting,” substance abuse, eating disorders, etc.). Their thinking processes are replete with trauma echoes (Gray, 1989); they often tell themselves what their perpetrators and non-supportive significant others told them (both explicitly and covertly) – that they are worthless, damaged in some fundamental way and to blame for their own abuse.

When youth are sexually or physically abusive (i.e., engaging in the Abuse Response), their thinking errors are externalized and directed toward others. They deny their actions or the responsibility for their actions, minimize their inappropriate or harmful behaviors, make excuses, and blame others for behaviors for their sexually abusive behavior (e.g., “She came on to me. She wanted it.”) (Lundrigan, 2001). Youth who engage in the Abuse response tend to be impulsive and have difficulty self-regulating their emotions and behaviors (Friedrich, 2002; Rasmussen, 2001). They especially have difficulty managing anger, which is often a delayed response to a prior trauma and provides the impetus driving a sex offense (Rasmussen, 2006, 2007). The Self-Victimization and Abuse responses are not mutually exclusive; a youth can experience either or both responses at different times subsequent to a traumatic experience. They are processes that either victims or offenders may experience, although victims tend to engage more in the Self-Victimization response, while the reverse is true for offenders. It is important to recognize however, that victims can sometimes be abusive, and that offenders are not only abusive, they can be self-victimizing.

In contrast to the maladaptive responses of Abuse and Self-victimization, the Recovery/Integration response consists of an adaptive behavioral pattern in which victims and/or offenders cope adequately with triggering events and are neither self-destructive nor abusive (Rasmussen, 1999; Rasmussen et al., 1992). Youth choose to engage in the Recovery/Integration response by recognizing and correcting inaccurate self-perceptions and distorted thinking processes (including trauma echoes), and taking appropriate responsibility for their own behavior. The Recovery/Integration response is characterized by consistent self-regulation of impulses, emotions and behaviors and adequate problem-solving skills, as opposed to manifesting impulsivity and poor judgment. In order to be in the Recovery response, youth cannot simultaneously engage in both the Self-victimizing and Abuse responses (Rasmussen, 2001).

Engaging in the Recovery/Integration response is contingent on the youth experiencing a safe and nurturing environment (Burton et al., 1998; Rasmussen, 1999, 2001). Through the developmentally sensitive interventions of the *TOPA* model, professionals can provide the safety and support that will enable the youth to revisit memories and feelings associated with their traumatic experiences. A strong therapeutic alliance provides a place where sexually abusive youth can: (a) clarify and sort out their own responsibility for their abusive behaviors from the responsibility their perpetrators have for victimizing them (Burton et al., 1998; Rasmussen, 1999); (b) express feelings associated with past trauma and/or current stressors; and (c) grieve losses as illustrated in the stages of grief delineated by Kubler-Ross (1969) (i.e., denial, anger, bargaining, depression, acceptance). Recovery/Integration is facilitated by “an attachment informed treatment environment” that acknowledges past difficulties of poor or disrupted attachments with parents or caregivers, allows the youth to experience a relationship with a therapist that is “genuine, respectful, and supportive while at the same time being structured and challenging” and “fosters social connection and the development of attached relationships” (Rich, 2007, p. 285).

Self-awareness of body sensations, thoughts, motivations, and actions (Miller et al., 1975) influences the choices a youth makes in response to a traumatic experience (or current stressors that trigger memories or feelings associated with traumatic experiences). The degree of self-awareness (including sexual awareness [Araji, 1997]) influences which of the behavioral responses in the Trauma Outcome Process (Abuse, Self-Victimization, or Recovery/Integration) will be most salient for a particular youth (Burton et al., 1998; Rasmussen, 1999, 2001, 2002a). Although self-awareness may be clouded by denial or other psychological defenses, at some level, a youth’s choice to engage in self-destructive and/or sexually abusive behavior is a conscious process (Burton et al., 1998; Rasmussen, 1999; Rasmussen et al., 1992).

Clinicians who have used the Trauma Outcome Process as a framework for their treatment of sexually abusive youth report that it is a powerful way to help sexually abusive youth become more aware of the impact of prior trauma, begin to engage in treatment, and find ways to express their feelings about the different traumatic events that they had experienced (D. Prescott, personal communication, May 10, 2007). The Trauma Outcome Process has also been found to help sexually abusive youth develop healthy coping strategies (including self-care) and begin to take responsibility for their lives (Schladale, 2002).

The *TOPA* model provides a comprehensive, multidimensional, ecologically based assessment of: (a) risk and resiliency factors at the individual, family dynamics, and ecological levels; and (b) outcomes of traumatic experiences (Rasmussen, 1999, 2001, 2004). Each youth has a unique combination of risk and resiliency factors that interact to influence his or her cognitive, emotional, and behavioral responses (Abuse, Self-Victimization, or Recovery/Integration) in response to trauma. Individual risk and resiliency factors relate to physiological and neuropsychological aspects (Miccio-Fonseca, 2001, 2007) and self-regulation of emotions and impulses (Friedrich, 2002; Rasmussen, 2001, 2007). Family risk and resiliency factors relate to the: (a) type of attachment (Friedrich, 2002; Rasmussen, 2001) and degree of empathy (Rasmussen, et al., 1992) that the youth experienced with parents and caregivers; (b) degree of enmeshment or disengagement among family members (Burton et al., 1998; Goldenberg & Goldenberg, 2007); and the family’s history of romantic and erotic bonding (Miccio-Fonseca, 2007). The interaction of individual and family risk and resiliency factors creates a “Self and Family Trauma Outcome Process” seen when family members react emotionally to each other’s behavioral responses to trauma (Brown & Rasmussen, 1994; Rasmussen & Brown, 2000). Ecological risk factors contributing to a youth becoming

sexually abusive and/or self-victimizing include: (a) cultural factors that covertly support abuse and violence and indirectly blame victims for their own abuse (Rasmussen, 1999; Rasmussen, Burton, Christopherson, Bradshaw, and Brown, 1997; Sinacore-Guinn, 1995); (b) violence in the community (e.g., gang violence, war, terrorism) (Boyd & Rasmussen, 2005; Miccio-Fonseca et al., 2005; Rasmussen, 2002b); (c) inadequate environmental support and lack of resources for the youth and his or her family (Gray & Pithers, 1993; Katz, 1997; Rasmussen, 2004). In contrast, ecological resiliency factors include supportive resources within the natural helping networks of the youth and his or her family (e.g., extended family, school, neighborhood, church, etc.) (Katz, 1997; Rasmussen, 2004). These resources provide a “safety net” (Katz, 1997) that helps create a “Prevention Team” (Gray & Pithers, 1993) of supportive, concerned adults that model positive behaviors and help ensure the youth’s success in avoiding further self-victimizing or abusive behavior (Rasmussen, 1999; 2004). Comprehensive discussion of how the *TOPA* model informs an assessment of a sexually abused and/or sexually abusive youth is beyond the scope of this brief article. For information about assessment, see other articles on the Trauma Outcome Process: Burton et al., 1998; Rasmussen, 1999, 2001, 2002, 2004; and Rasmussen et al., 1992.

Summary: The *TOPA* model is a multidimensional, developmentally and culturally sensitive ecological paradigm that views a youth’s sexual behavior holistically, as “part of a bigger picture” (Longo & Prescott, 2006, p. 40) that includes their neuropsychological functioning, family dynamics, culture, and community. The *TOPA* model explains responses to trauma common to humankind and has been shown to be applicable to youth in diverse target populations nationally and internationally. These include: Israelis and Israeli immigrants from Europe, Asia, and Africa (Rasmussen, 2002b, Miccio-Fonseca et al., 2005); Mexicans residing in Baja California, Mexico (Rasmussen & Kelley, 2003); Asians and Pacific Islanders (Rasmussen, 2006a); and Native Americans (Rasmussen, 1997). With the *TOPA* model, professionals can complete comprehensive assessments and provide developmentally sensitive, and culturally competent treatment to sexually abusive youth (Rasmussen, 1999, 2001, 2004; 2006, 2007).

¹I appreciate collaborating with Jan Ellen Burton, Barbara Christopherson, Julie Bradshaw, and Arthur Brown, III when we first created the Trauma Outcome Process. I acknowledge the contribution of Alison S. Gray, who inspired me to think about and formulate the concepts on which the Trauma Outcome Process is based. I thank my esteemed colleagues, L.C. Miccio-Fonseca and Barbara Reicher for their valuable and insightful feedback as I was updating the Trauma Outcome Process model (now *TOPA*). Lastly, I recognize and appreciate the work of those clinicians who have demonstrated how the Trauma Outcome Process is applied in clinical practice, including Steven Huke, JoAnn Schladale, and David Prescott. For further information about the *TOPA* model, please contact me at 619-594-6459 or at lucindarasmussen@cox.net.

References:

- American Polygraph Association (APA) (2004a, February). Division III, *Standards of Practice*. Chattanooga, TN: American Polygraph Association (APA), APA National Office.
- American Polygraph Association (2004b, February). Division V, *By Laws Standards of Practice*. Chattanooga, TN: American Polygraph Association (APA), APA National Office.
- Araji, S. (1997). *Sexually aggressive children: Coming to understand them*. Thousand Oaks, CA: Sage.
- Becker, J. (1998). What we know about the characteristics and treatment of adolescents who have committed sex offenses. *Child Maltreatment*, 3(4), 317-329.
- Becker, J. V., & Kaplan, M. S. (1993). Cognitive-behavioral treatment of the juvenile sex offender. In: In H. Barbaree, W. Marshall, & S. Hudson (Eds.), *The juvenile sexual offender* (pp. 264-277). New York: Guilford Press.
- Brown, A. H., & Rasmussen, L. A. (1994, November). *Environmental contributors to sexually offending behavior: A family systems application to the trauma outcome process*. Paper presented at the 13th

Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, San Francisco, CA.

Burton, D. L., Fiske, J. A., Freeman-Longo, R. E., & Levins, J. (1996). *The 1996 nationwide survey of sexual abuse treatment providers and programs*. Brandon, VT: Safer Society.

Burton, J., Rasmussen, L. A., Bradshaw, J., Christopherson, B. J., & Huke, S. C. (1998). *Treating children with sexually abusive behavior problems: Guidelines for child and parent intervention*. NY: Haworth Press.

Center for Sex Offender Management (1999, December) *Understanding juvenile sexual offending behavior: Emerging research, treatment approaches and management practices*. San Diego, CA: Center For Sex Offender Management.

Chaffin, M., & Bonner, B. (1998). "Don't shoot, we're your children": Have we gone too far in our response to adolescent sexual abusers and children with sexual behavior problems? *Child Maltreatment*, 3(4), 314-316.

Chaffin, M., Letourneau, E., & Silovsky, J. (2002). Adults, adolescents, and children who sexually abuse children. In J. E. B. Meyers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed.) (pp. 205-232). Thousand Oaks, CA: Sage.

Colorado Sex Offender Management Board (2003, July). *Standards and guidelines for the evaluation, assessment, treatment and supervision of juveniles who have committed sexual offenses*. (*I don't think we need to specify the sections of this document that we checked* - Section 7, Appendix D) Denver, CO: Colorado of Public Safety, Division of Criminal Justice and Sex Offender Management. Retrieved February 28, 2005 from: http://dcj.state.co.us/obvsom/Sex_Offender/SO_Pdfs/2003JUVENILESTANDARDS.pdf

Friedrich, W. N. (2002). *Psychological assessment of sexually abused children and their families*. Thousand Oaks, CA: Sage.

Gray, A. S. (1989, March). New concepts in sexual abuse recovery: Healing the effects of trauma. Paper presented at the National Adolescent Perpetrator Network Fourth Annual Training Conference on the Treatment of Juvenile Sex Offenders, Salt Lake City, UT.

Gray, A. S., & Pithers, W. D. (1993). Relapse prevention with sexually aggressive adolescents and children: Expanding treatment and supervision. In H. Barbaree, W. Marshall, & S. Hudson (Eds.), *The juvenile sexual offender* (pp. 289-319). New York: Guilford Press.

Hunter, J. A. (2006). Understanding diversity in juvenile sexual offenders: Implications for assessment, treatment, and legal management. In R. E. Longo & D. S. Prescott (Eds.), *Current perspectives in working with sexually aggressive youth and youth with sexual behavior problems* (pp. 63-77). Holyoke, MA: NEARI Press.

Hunter, J. A., & Lexier, L. J. (1998). Ethical and legal issues in the assessment and treatment of juvenile sex offenders. *Child Maltreatment*, 5(4), 339-348.

Janes, B. (1993, June). Polygraph: A current perspective. *Interchange: Cooperative Newsletter of the National Adolescent Perpetrator Network*, 1-6.

- Jenkins, A. (2006). Discovering integrity: Working with shame without shaming young people who have abused. In R. E. Longo & D. S. Prescott (Eds.), *Current perspectives in working with sexually aggressive youth and youth with sexual behavior problems* (pp. 419-442). Holyoke, MA: NEARI Press.
- Katz, M. (1997). *On playing a poor hand well: Insights from the lives of those who have overcome childhood risks and adversities*. New York: W. W. Norton.
- Kubler-Ross, E. (1969). *On death and dying*. New York: Macmillan Publishing. \Lane, S. (1997b). The sexual abuse cycle. In G. Ryan & S. Lane (Eds.), *Juvenile sexual offending: Causes, consequences, and correction* (Rev. ed., pp. 77-121).
- Longo, R. E. (2004). An integrated experiential approach to treating young people who sexually abuse. *Journal of Child Sexual Abuse*, 13(3/4), 193-213.
- Longo, R. E., & Prescott, D. S. (2006). Introduction. In R. E. Longo & D. S. Prescott (Eds.), *Current perspectives in working with sexually aggressive youth and youth with sexual behavior problems* (pp. 31-43). Holyoke, MA: NEARI Press.
- Lundrigan, P. S. (2001). *Treating youth who sexually abuse: An integrated multi-component approach*. New York: Haworth Press.
- Miccio-Fonseca, L. C. (1999 - Revised 2002, 2003, 2004, 2005). *Fonseca Inventory of Sex Offenders' Risk Factors (FISORF) – Professional Manual*. San Diego, CA: Author.
- Miccio-Fonseca, L. C. (2000). Adult and adolescent female sex offenders: Experiences compared to other females and male sex offenders. *Special Edition, Journal of Psychology & Human Sexuality*, 11, 75-88.
- Miccio-Fonseca, L. C. (2001) Somatic and mental symptoms of male sex offenders, A comparison among offenders, victims, and their families. *Journal of Psychology and Human Sexuality*, 13, 103-114.
- Miccio-Fonseca, L. C., & Rasmussen, L. A. (2006b). *Implementing MEGA, a new tool for assessing risk of concern for sexually abusive behavior in youth ages 19 and under: An empirically guided paradigm for risk assessment: Revised version*. Available from, www.ccoso.org.
- Miccio-Fonseca, L. C., Rasmussen, L. A., & Fredericks, M. H. (2005, May). *A comprehensive ecologically valid protocol for assessing sexually abusive youth ages 19 and under: A risk factor approach to guiding interventions and providing treatment*. Invited seminar sponsored by the Israeli Association for Child Protection (ELI), Tel Aviv, Israel.
- Miller, S., Nunnally, E. W., & Walkman, D. B. (1975). *Alive and aware: Improving communication in relationships*. Minneapolis, MN: Interpersonal Communication Program.
- Miner, M. H. (2002). Factors associated with recidivism in juveniles: An analysis of serious juvenile offenders. *Journal of Research in Crime and Delinquency*, 39(4), 421-436.
- National Task Force on Juvenile Sexual Offending (1993). The revised report of the National Task Force on Juvenile Sexual Offending, 1993 of the National Adolescent Perpetrator Network. *Juvenile & Family Court Journal*, 44(4), 5-120.

- Prescott, D. S., & Longo, R. E. (2006). Current perspectives: Working with young people who sexually abuse. In R. E. Longo & D. S. Prescott (Eds.), *Current perspectives in working with sexually aggressive youth and youth with sexual behavior problems* (pp. 45-61). Holyoke, MA: NEARI Press.
- Rasmussen, L. A. (1989, May). Cycles of self-victimization, abuse, and recovery. Unpublished manuscript. Sandy, UT: Author.
- Rasmussen, L.A. (1997, August). *Post-traumatic stress disorder and vicarious traumatization: Assessing and treating sexually abused children*. Invited workshop to Riverside Indian Health Services, Riverside, CA.
- Rasmussen, L. A. (1998, October). *The Trauma Outcome Process: Applications to the assessment and treatment of domestic violence*. Paper presented at the Fourth International Conference on Children Exposed to Family Violence, San Diego, CA.
- Rasmussen, L. A. (1999a). Factors related to recidivism among juvenile sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 11(1), 69-85.
- Rasmussen, L. A. (1999b). The trauma outcome process: An integrated model for guiding clinical practice with children with sexually abusive behavior problems. *Journal of Child Sexual Abuse*, 8(4), 3-33.
- Rasmussen, L. A. (2001). Integrating cognitive-behavioral and expressive therapy interventions: Applying the trauma outcome process in treating children with sexually abusive behavior problems. *Journal of Child Sexual Abuse*, 10(4), 1-29.
- Rasmussen, L. A. (2002a). An integrated systemic approach to intervention with children with sexually abusive behavior problems. In M. Calder (Ed.), *Young people who sexually abuse: Building the evidence base for your practice*. United Kingdom: RHP Publications.
- Rasmussen, L. A. (2002b, February). *The Trauma Outcome Process: An integrated model for understanding, identifying, assessing, and treating children with sexually abusive behavior problems*. Invited keynote address and 2-day workshop presented at the Conference on Children Hurting Children, Tel Aviv, Israel.
- Rasmussen, L. A. (2004). Differentiating youth with sexual behavior problems: Applying a multidimensional framework when assessing and treating subtypes. *Special Edition, Journal of Child Sexual Abuse*, 13(3/4), 57-82.
- Rasmussen, L. A. (2006, March). *Assessing and treating children and adolescents who sexually abuse using the Trauma Outcome Process Assessment (TOPA) model*. Invited all-day seminar at the 3rd Annual Assessing and Treating Childhood, Adolescent, and Adult Trauma Conference, Institute on Violence, Abuse, and Trauma, Honolulu, HI.
- Rasmussen, L. A. (2007). Expanding the Trauma Outcome Process Assessment (TOPA) model: New insights in identifying and assessing responses to traumatic experiences. Poster presentation at the 10th Annual Conference of the California Coalition on Sexual Offending, La Jolla, CA.
- Rasmussen, L. A., & Brown, A. H. (2000, November). Family interventions with juveniles who offend sexually: The power of multiple family group therapy. Paper presented at the 19th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, San Diego, CA.

- Rasmussen, L. A., Burton, J., & Christopherson, B. J. (1990, October). *Interrupting precursors to perpetration in males ages 4 to 12*. Workshop at the Fifth Annual National Training Conference of the National Adolescent Perpetrator Network, Albany, NY.
- Rasmussen, L. A., Burton, J., & Christopherson, B. J. (1992). Precursors to offending and the Trauma Outcome Process in sexually reactive children. *Journal of Child Sexual Abuse, 1*(1), 33-48.
- Rasmussen, L. A., Burton, J., Christopherson, B. J., Bradshaw, J., & Brown, A. H. (1997). *Trauma Outcome Process*. Graphic. Sandy, UT: Authors.
- Rasmussen, L. A., & Cunningham, C. (1995). Focused play therapy and non-directive play therapy: Can they be integrated? *Journal of Child Sexual Abuse, 4*(1), 1-20.
- Rasmussen, L. A., & Kelley, M. T. (2003, September, November, and December). *The Trauma Outcome Process: Interventions with traumatized and trauma reactive children and their families, Parts 1-3*. Invited presentations sponsored by the Collegio de Trabajar Social, Ciudad de los Ninos, Tijuana, Baja California, Mexico.
- Rasmussen, L. A., & Miccio-Fonseca, L. C. (2007a). Empirically guided practice with young people who sexually abuse: A risk factor approach to assessment and treatment. In M. Calder (Ed.), *Children and young people who sexually abuse: Taking the field forward*. United Kingdom: RHP Publications.
- Rasmussen, L. A., & Miccio-Fonseca, L. C. (2007b). Paradigm shift: Implementing *MEGA*[®], a new tool proposed to define and assess *Sexually Abusive Dynamics* in youth ages 19 and under. *Journal of Child Sexual Abuse, 16*(1), 85-106.
- Rich, P. (2003). *Understanding, assessing, and rehabilitating juvenile sexual offenders*. Hoboken, NJ: John Wiley.
- Righthand, S., & Welch, C. (2001). *Juveniles who have sexually offended: A review of professional literature*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.
- Righthand, S., & Welch, C. (2004). Characteristics of youth who sexually offend. *Journal of Child Sexual Abuse, 13*(3/4), 15-32.
- Ryan, G. (1997). Perpetration prevention. In G. Ryan & S. Lane (Eds.), *Juvenile sexual offending: Causes, consequences, and correction* (Rev. ed., pp. 433-454). San Francisco: Jossey-Bass.
- Ryan, G., & Lane, S. (1997). *Juvenile sexual offending: Causes, consequences, and correction* (Rev. ed.). San Francisco: Jossey-Bass.
- San Diego County Sex Offender Management Council (2005). *Standards for the treatment of sexually abusive youth: Approved by the San Diego County Sex Offender Management Council*. Retrieved February 27, 2005 from: http://www.sdsomc.com/images/Juv_tx_standards.pdf
- Schladale, J. (2002). *The TOP workbook for taming violence and sexual aggression*. Freeport, ME: Resources for Resolving Violence.
- Sinacore-Guinn, A. L. (1995). The diagnostic window: Culture- and gender-sensitive diagnosis and training. *Counselor Education and Supervision, 35*, 18-31.

- Swenson, C. C., Henggeler, S. W., & Schoewald, S. K. (1998). Changing the social ecologies of adolescent sexual offenders: Implications of the success of Multisystemic Therapy in treating serious antisocial behavior in adolescents. *Child Maltreatment, 3*(4), 330-339.
- Steen, C. (1993). *The relapse prevention workbook for youth in treatment*. Brandon, VT: Safer Society.
- Utah Department of Human Services: Division of Juvenile Justice Services. (2005). JJS overview: Who does JJS serve? Retrieved March 11, 2005 from: <http://www.hsdyc.state.ut.us/overview.htm>
- Venziano, C., & Venziano, L. (2003). Adolescent sex offenders: A review of the literature. *Trauma, Violence, & Abuse, 3*(4), 247-260.
- Weinrott, M. (1996). *Juvenile sexual aggression: A critical review*. Boulder, CO: University of Colorado, Institute for Behavioral Sciences, Center for the Study and Prevention of Violence.
- Worling J. R., & Curwen, T. (2000). Adolescent sexual offender recidivism: success of specialized treatment and implications for risk prediction. *Child Abuse & Neglect, 24*, 965-982.