

When Days Are Gray: Avoiding Burnout as Child Abuse Professionals*

By Victor Vieth¹

"Children suffer not (I think) less than their elders but differently."
C.S. Lewis²

Child abuse professionals are engaged in a high stress, high burnout calling. Unless and until this fact is adequately addressed, we will continue to see high turnover rates among child abuse professionals. Several common reasons for this burnout, and some possible solutions are offered in this article.

FACTORS CONTRIBUTING TO BURNOUT

First, child protection officials are seldom honored in their departments and communities. Some years ago, I spoke with a police officer handling nothing but cases of child abuse. The officer told me that many of her colleagues, such as those working in the drug unit, were honored for their labor. The narcotics officers executing a search warrant returned to the police station with guns, scales, drugs, money and other mcooloo stuff. Their fellow officers lavished praise on them for doing a good, even noble act. But the child abuse officer told me that when she executes a search warrant, she returns to the police station with dildos, child pornography, Vaseline and other items that cause her colleagues to wrinkle their noses and inquire mhow can you deal with this sick stuff all the time?o Nobody in her department, card club, church or neighborhood wanted to listen to her lament about the children keeping her awake at night.

Second, child abuse professionals are actually dishonored. This is true even when the child abuse official does a stellar, sometimes heroic deed. As an example of the abuse inflicted on social workers, consider the following scenario. After New York social worker Marc Parent talked a troubled youth out of killing a younger sibling, both children were taken into custody. According to Parent, the mother of the children called and mhand-delivered a first class ranting before I could even say hello. The attacks flew out of her mouth like rusty nails"³

Hostility comes not only from the victims and their families but also from the media, judges, and fellow service providers. As one commentator notes:

Service recipients, members of the judiciary, and other co-professionals occasionally offer resistance by being verbally hostile, accusatory, and demanding. These responses can make the case load seem undesirable and can easily lead workers to feelings of inadequacy, loss of self-worth, and a question of 'Is it worth it?'"⁴

Third, college, graduate and law schools seldom prepare students for the reality that is child protection. Reporter Anna Quindlen describes a social worker's obstacles as follows:

Their training is inadequate, and the number of workers is too small for the

number of families in trouble. Some of the cases would require a battalion of cops, doctors, and social workers to handle; instead there are two kids fresh out of college with good intentions and a handful of forms.⁵

Commenting on his lack of training, Marc Parent said he received two weeks of solemn discussions on child protective issues, but little on getting a drug dealer to let you into an abandoned building or talking a restless police officer into sticking around until you get through with a case and back into your car."⁶

Fourth, the drumbeat of beaten, burned, bound, bludgeoned, raped and murdered children will, eventually, take its toll. We may pretend not to feel the pain but, for that to really be the case, we would have to be cold blooded. The impact may come subtly. We're afraid to let our children sleep over at a friend's house. We start to inspect the bruise of every playground child and wonder whether or not it is suspicious. We talk of torn hymens while we dine and wonder why our spouses lose interest in the food. Then, all of a sudden, it hits us. We are our work.

SUGGESTIONS FOR REDUCING BURNOUT

It is not enough to recognize the reality of burnout among child abuse professionals, we must be proactive in combating it. Toward this end, consider the following suggestions.

First, be well trained. If for example, your job involves speaking to children, make sure you have a thorough grounding in child development, memory and suggestibility research, and linguistics.⁷ Adequate training will produce stronger cases and fewer opportunities for defense attorneys, the public, and others to hurl rocks in your direction. Training also allows you to take a breather, reflect, and then develop the best practices. Training energizes child abuse professionals and gives us important contacts that can assist in the handling of difficult cases.

If you are a supervisor, make sure your budget allows for adequate training opportunities not only as a means of delivering quality service to the community, but as a means of assuring the emotional well-being of the keepers of the children.

Second, support the members of your multi-disciplinary team. Make a concerted effort to get together on regularly scheduled social outings as a means of unwinding and offering each other support. If your jurisdiction does not have a multi-disciplinary team, this is one more reason to start one.

Third, praise one another often and in public. Press releases announcing a child abuse conviction should include public praise for the investigators and prosecutors handling the case. In addition, send personal thank you notes to all the workers involved in the case. Rather than a form letter, take the time to understand why the work of the child protection professional made a difference and commend the work accordingly. It can be as simple as writing myour interrogation of the suspect was extremely helpful in convincing the jury how unbelievable the defendant's story was. In the same vein, prosecutor organizations, bar associations and other groups should give awards or other recognition to those who do the job of child protection and who excel.

Fourth, keep a file of thank you letters you receive from victims and colleagues over the years. Whendays are gray and defeatism starts to set in, take a look at the file and remind yourself that sometimes you do make a difference. I know a prosecutor who keeps a collage in his office of the artwork child abuse victims sent to him over the years as a means of expressing their gratitude.⁸

Fifth, consider the option of periodically leaving the work of child abuse.

Choosing to handle drug or other cases for a time may allow you to get rejuvenated and come back to the child abuse unit with renewed energy. In some cases, it may not be necessary to leave the work of child abuse altogether but simply to handle a different aspect of it. For example, handling civil as opposed to criminal child protection cases may be sufficient.

If you take a respite from your traditional duties, do not come back until you are ready. Well-meaning colleagues who miss you may encourage you to come back or may repeatedly contact you for advice on difficult cases. Make it clear that you are making a temporary, but clear break from child protection work and that you will return when you are emotionally able to do so.

Sixth, find a unique approach to motivation. Recognize that the nature of our work puts us in the middle of broken homes overflowing with emotion and that we will inevitably be verbally abused, even by the victims we are trying to protect. To put this in perspective, remember you are not alone. Remember the words of Earl Warren, "everything I did in my life that was worthwhile, I caught hell for."⁹ Better yet, have these words matted, framed and hung in your office.

Some child abuse professionals may rely on their faith to sustain them. Prosecutors such as Robert Kennedy and Christopher Darden have found religion helpful in coping with the injustices of our justice system and of life itself.¹⁰ Creighton University Law Professor Joseph G. Allegretti suggests the high burnout rate in the legal profession is in part attributable to the fact that lawyers do not rely on their faith to sustain them in their work."¹¹

Seventh, never lose heart. As child abuse professionals, we know our lot in life is different from the lot of others. Other people may read, see, and hear the ugliness of the world but, by and large, they do so from behind the security of their newspapers, radios and television sets. We, on the other hand, experience the ugliness of the world up close and personal. We actually hear the quivering voice of a child who speaks to us about abuse. We actually see the disfigured face of a woman beaten solely because doing so made somebody feel strong.

We learn of a man in Waco, Texas who sexually abuses children in the name of God. We learn of another man in Oklahoma who bombs children in the name of patriotism and, at some point, we begin to wonder if the whole world is insane, or is it us? If you have ever had a thought like this, perhaps you will find comfort in the words of Cesar Chavez who, in a speech in 1967, said:

When we are really honest with ourselves, we must admit our lives are all that

really belong to us. So it is how we use our lives that determines what kind of men we are. It is my deepest belief that only by giving our lives do we find life. I am convinced that the truest act of courage, the strongest act of manliness, is to sacrifice ourselves for others in a totally no-violent struggle for justice. To be a man is to suffer for others. God help us be men.¹²

If you are not sure you have ever been near a hero or heroine, take a look at your colleagues. If you are not sure you have ever looked into the eyes of someone you knew to have courage, don't let the sun set tonight without looking in a mirror.

The weakest, the most precarious of vessels floating on the stream of life are those rafts occupied by abused children. For your willingness, even eagerness to commandeer one of these little boats, may God richly bless you.

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² C.S. LEWIS, *SURPRISED BY JOY* 18 (1955).

³ MARC PARENT; *TURNING STONES: MY DAYS AND NIGHTS WITH CHILDREN AT RISK* 29 (1996).

⁴ LORI HOMES & INTA SELLARS, *A GUIDE FOR CHILD PROTECTION SERVICES, LAW ENFORCEMENT, AND COUNTY ATTORNEYS IN MINNESOTA*, SECOND EDITION AT 8-9 (1997) (citations omitted) .

⁵ Anna Quindlen, *Foreword* to MARC PARENT, *TURNING STONES: MY DAYS AND NIGHTS WITH CHILDREN AT RISK* (1996).

⁶ *Id.* At 42.

⁷ This training is available at *Finding Words*, a course offered by APRI's National Center for Prosecution of Child Abuse.

⁸ The prosecutor is Brian Holmgren in the office of the District Attorney, Nashville, Tennessee.

⁹ This quotation appears in a postcard advertising the PBS broadcast of *Super Chief: The Life and Legacy of Earl Warren*.

¹⁰ See Victor I. Vieth, *Do Lawyers Need Religion?* 80 *BENCH & BAR* 30 (September 1996).

¹¹ See generally, JOSEPH G. ALLEGRETTI, *THE LAWYER'S CALLING* (1996)

¹² ARTHUR M. SCHLESINGER, JR., *ROBERT KENNEDY AND HIS TIMES* 910 (1978).

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**Presentation to the Maine Health & Human Services Committee
On Child Protective and Foster Care Services
Lawrence R. Ricci, MD**

This testimony was given by Lawrence R. Ricci, MD on October 12, 2001 to the legislatively established Maine Health & Human Services Committee on Child Protective and Foster Care Services.

Good afternoon, and thank you for this opportunity to speak with you on an issue vital to the health, welfare, and safety of Maine's children..

My name is Lawrence Ricci and I am a pediatrician who has specialized in the evaluation and treatment of abused children in this state for the past 15 years. I am Chair of the Maine Child Death and Serious Injury Review Panel and director of The Spurwink Child Abuse Program, a multidisciplinary child abuse evaluation and treatment center in Portland with satellites throughout the state. Our program evaluates 600 children and 200 adults yearly. In the context of our multidisciplinary team evaluations, in addition to performing medical evaluations of these children, we also perform expert evidentiary interviews of children and psychological evaluations of children and adults. Our staff includes medical providers, social workers, and psychologists.

I would like to take my time today to do two things. First I would like to describe for you some of the Maine families that we have evaluated. Second I would like to talk to you, albeit briefly, about what we have learned and what the medical literature tells us about children in foster care in the United States. Along with a copy of my presentation, I have included for your review a copy of a letter that I wrote in September to the editor of the "Portland Press Herald" and copies of two recent articles published in "Pediatrics" on foster care.

Let me start by describing for you some of the families that we see at The Spurwink Child Abuse Program. Based on a number of different analyses that we have done, including a recent analysis published in the journal "Child Abuse and Neglect", I can tell you the following things about our children and their parents.

Our referral sources are primarily medical providers, accounting for almost 40%, and Child Protective Services, accounting for another 40%. The average age of children that we evaluate is 5, with an equal percentage of males and females.

Approximately 50% of the families report an annual family income of less than \$15,000 a year, while 36% report an annual income of less than \$10,000 a year thus indicating that close to half of the families that we evaluate fulfill the poverty definition of the U. S. Census Bureau. Twenty-five percent of the homes are run by a single parent, while fully 50% of the children live in homes where parents are separated or divorced.

The average IQ of the children we have evaluated is 87 which is well below the normal average of 100. We found that many children present to us with a significant behavioral problems, both internalizing, such as depression, and externalizing, such as aggressive and sexual behaviors.

Approximately 40% of the children we psychologically evaluate receive a diagnosis from us of oppositional defiant behavioral disorder while 15% receive a diagnosis of attachment disorder.

We found overall that sexual abuse was present in 15% of children we evaluated for sexual abuse, physical abuse was present in 60% of the children we evaluated for physical abuse, and emotional abuse was present in virtually 100% of the children we evaluated for emotional abuse. We felt that many of these children along with their parents require mental health treatment. Many parents also require parenting education. The children often need developmental evaluation, and their parents often needed substance abuse evaluations, domestic violence evaluations, and in some cases sex offender evaluations. We are of course often asked to offer the department a recommendation on placement.

In assessing parenting, our standard is what has been called “good enough parenting”; i.e., we are not interested in identifying whether a parent can do a great job, but only whether parents can provide certain levels of basic care for their children, whether they can feed them, clothe them, obtain medical care and schooling, keep them from harm and of course not abuse them themselves. We look for such things as empathy, problem solving ability, protective judgment, behavior management ability, and stress management ability. We found in our work that certain factors, such as the presence of domestic violence, substance abuse, criminality, depression, cognitive limitations, and child abuse in the parents’ own childhood, often interacted within the context of significant core personality problems to lead to the final outcome of child abuse in its broadest definition to include neglect. Virtually 100% of the parents who we found had serious parenting problems also suffered from a significant personality disorder and the majority scored high in the Child Abuse Potential Inventory, a measure of the child abuse potential of a parent that was standardized using a prison population of convicted child abusers.

- Domestic violence occurs in 60% of these homes and in the overwhelming majority children are directly exposed to if not involved in the violence.
- Child abuse in the parents own childhood is present in 70% of these families.
- Substance abuse is present in well over 50% of these families.

Given that backdrop, let me describe to you a few of our cases:

We were asked to evaluate the question of whether there should be reunification between one or both parents when another child has been killed by one or the other of these parents. We found that although neither law enforcement nor child protective services nor we could determine which parent had killed the child, we did find evidence of significant personality disorders in both parents, raising in and of itself concerns about parenting.

We were asked to evaluate the question of reunification with a non-offending mother of a 3 month old brain damaged child who had been a victim of shaken baby syndrome at the hands of the father. In that particular case, the psychological evaluation of the mother was not at all problematic. Indeed, the evidence was clear that the mother had no part in either abusing or not protecting her child.

We were asked to evaluate a woman who had been convicted of murdering a child and who had had another child since that time. The question for us was her protective ability around the new child. The psychological data, in contrast to the reports of community professionals, revealed a severely problematic personality disordered parent with significant impulse control problems.

We looked at three children where there had been allegations of sexual acting out behavior among the children in the context of a parent who seemed unable to protect the children from themselves, much less from other possible perpetrators. The results of this evaluation indicated very problematic parenting and significant sexual behavior problems on the part of the children, leading us to conclude that reunification would be potentially dangerous for the children.

We looked at a young infant with failure to grow in the care of a teen mother who, although most likely she loved her child as do most of the parents we see, was completely ill prepared to provide even routine nutritional care despite multiple in-home services.

Finally, we looked at two girls who presented with allegations of sexual abuse by their father. These allegations had prevented the father from having contact with his daughters for well over a year. Our evaluation found no evidence of sexual abuse and reunification occurred.

As you can see from the above descriptions, child abuse is not a single entity with a single face and name. It encompasses many forms of possible abuse in many different kinds of families. The trick, of course, is to figure out what the particular issues are in a particular family and either resolve those issues or, if necessary, remove the child for his or her own safety.

I have for 15 years argued that the best way to address the issues of child abuse in this state are, first and foremost, to get the diagnosis right. As you know, medical treatment without an accurate diagnosis may not only be worthless but dangerous. Likewise, the treatment of families and children where child abuse is a concern cannot benefit children and their families or, indeed, protect children without an accurate diagnosis. I believe the best way to arrive at such diagnoses is through skilled multidisciplinary evaluations using the best available science.

That science by the way also tells us that:

- Biological parenthood does not necessarily confer the desire or ability to care for a child adequately. Love simply is not enough
- Supportive nurturing by primary caregivers is crucial to early brain development and to the physical, emotional, and developmental needs of children. The issue is not blood but demonstrated care.
- Children need continuity, consistency, and predictability from their caregivers. Multiple placements are injurious.
- Attachment, a sense of time, and the developmental levels of the child are key factors in the adjustment to environmental and internal stressors.
- Parents should be given reasonable assistance and opportunity to maintain the family while the present and future best interests of the child should determine what is appropriate.
- Past attachment history and sense of time should guide the pace of decision making.

- Foster care placement should always maximize the healing aspect of foster care and be based on the needs of the child.
- Foster care placement with relatives should be based on careful assessment of the needs of the child and of the ability of the kinship care to meet those needs. As with all foster care placement, kinship care must be supported and supervised adequately.

The notions that reunification is the optimal outcome for children and/or that children are more likely to be abused in foster care rather than in their biological homes are simply not supported by the literature. A study entitled “Children who Return Home from Foster Care, a Six-Year Prospective Study of Behavioral Health Outcomes in Adolescents” found that compared with children who were not reunified, reunified children showed more self-destructive behavior, more substance abuse, and more overall risk behavior problems. They were more likely to have been arrested, to have dropped out of school, and to have received lower grades. Other studies support these results. Even studies where former foster children were interviewed report that these children generally have positive feelings about having been placed in foster care. Most of these children thought that it was in their best interest and reported that things would have gotten worse at home without child welfare intervention.

We have seen over the past several years an explosion in the number of children in foster care, not just in Maine but throughout the United States. In part, this reflects changes in our national philosophy that children should not stay in biological homes where they are being abused and neglected. The Adoption and Safe Family Act of 1997 clearly has moved us in the direction of early permanency planning and protection of children and away from the notion that preserving families at all costs is in the best interests of children. This increase also reflects an increase in the late 20th century in the incidence of substance abuse in families, single parent families, homelessness, child poverty, and the overall incidence of child abuse.

We have also seen in the past few years a dramatic decrease in the number of children in this country who are substantiated for abuse. The number of children who are substantiated for sexual abuse and physical abuse has decreased 30% over the past few years. Many, including myself, believe that these decreases are a direct result of aggressive intervention on the part of child welfare services both in Maine and around the country. Child abuse continues to be a serious problem, but it is not the same problem in Maine or the United States that it was 30 years ago. Thirty years ago when I began practicing medicine I would routinely see children who were profoundly battered and/or severely neglected and who presented with many months, if not years, of abuse that had been ignored by medical providers, schools, neighbors, and others. Indeed, many of those children, when evaluated medically, would return home only to be further abused if not killed by their parents. Thankfully, those days of systemic apathy are over. Children are better off now that they were 30 years ago primarily due to improved and aggressive child welfare services.

Finally, as we think of the tragedy of Logan Marr, we also must not forget other names:

- Heather Discher (aged 12 days) was shaken to death by her father.
- Jeffrey Hart (aged 5) was killed by Mary Ann Fitzherbert, his stepmother, because he lied to her about a bar of soap.

- Alexander McKenney (aged 7 months) was smothered to death by his father.
- Warren Skidgel (aged 2 months) was shaken to death by his father.
- Kristin Bouthot (aged 1) was stabbed and burned in a mobile home fire by her father.
- James Dedekian (aged 2 months) was suffocated by his mother who piled clothes on top of him to stifle his crying.

The names go on: Chase Crowley, Jennifer Smith, Matthew Ardolino, Tavielle Kigas, Aaron Bennett, David Ducette, Aisha Dickson, Kelsie Marie Glenn, Victoria Rose Dale, Jenna Nicole Crabtree, Victor Lizotte, Ashlie Grant, Zachary Allen, Sarina Towle, Georgeanne O'Palenick; John Glidden, Raymond Glidden, Deanna Marie Wadsworth, Faith St. Yves, Jake Belisle, Chelsea Taplin. None of these children were killed in foster care.

I firmly believe that science not anecdote should guide all of us in making decisions about our children's best interests. I believe that through scientific inquiry and reasoning, we can arrive at the best approach in dealing with child abuse in general and with individual child abuse cases as well.

It is my hope that this committee in its deliberations also considers what science can tell us as you consider how to address the issues of welfare and above all safety for the children of Maine.

Thank You

References

American Academy of Pediatrics. Committee on Early Childhood and Adoption and Dependent Care. Developmental issues for young children in foster care. *Pediatrics*. 2000;106(5):1145-50.

Fisher PA, Gunnar MR, Chamberlain P, Reid JB. Preventive intervention for maltreated preschool children: impact on children's behavior, neuroendocrine activity, and foster parent functioning. *J Am Acad Child Adolesc Psychiatry*. 2000 Nov;39(11):1356-64.
Pediatrics. 2000 Nov;106(5):1145-50.

Drach KM, Wientzen J, Ricci LR. The diagnostic utility of sexual behavior problems in diagnosing sexual abuse in a forensic child abuse evaluation clinic. *Child Abuse Negl*. 2001 Apr;25(4):489-503.

Ricci LR, Giantris A, Merriam P, Doyle T. Abusive Head Trauma in Maine Infants: Medical, Child Protective, and Law Enforcement Analysis. (in preparation)

Simms MD, Dubowitz H, Szilagyi MA. Health care needs of children in the foster care system. *Pediatrics*. 2000 Oct;106(4 Suppl):909-18.

Taussig HN, Clyman RB, Landsverk J. Children who return home from foster care: a 6-year prospective study of behavioral health outcomes in adolescence. *Pediatrics*. 2001 Jul;108(1):E10.

Zeanah CH, Larrieu JA, Heller SS, Valliere J, Hinshaw-Fuselier S, Aoki Y, Drilling M.
Evaluation of a preventive intervention for maltreated infants and toddlers in foster care. *J Am Acad Child Adolesc Psychiatry*. 2001 Feb;40(2):214-21.

Sex Offending by Maine Youths: A Brief Report

By: Sue Righthand, Ph.D.¹

Sexual abuse has been recognized as a significant problem in our society. Adult sex offenders frequently begin their abusive behavior during their adolescence, or even younger (Abel, Mittelman, & Becker, 1985; Groth, Longo, & McFadin, 1982). In addition, sexual abuse by juveniles results in significant numbers of victims (Araji, 1997; Weinrott, 1996). For example, Federal Bureau of Investigation data (as cited in Sipe, Jensen, & Everett, 1998) indicated that, in 1995, 16% of arrests for forcible rape and 17% of arrests for all other sex offenses involved youths under 18 years old.

Across the country, as communities have become more aware of the problem of juvenile sex offending, they often have responded with legislation for stiffer sentences and community notification. These severe responses are in spite of recidivism data suggesting that a relatively small group of juveniles commit repeat sexual offenses after there has been an official response to their sexual offending (Righthand & Welch, 2001). Furthermore, studies of those who commit additional offenses have indicated that most youths who recidivate do so with nonsexual crimes. Additionally, research findings on juvenile offending in general indicate that most youths who perpetrate crimes subsequently desist.

In view of these findings, it is important to identify the youths who present the greatest risk of reoffending, as well as what can be done to help reduce this risk. Because youths who sexually offend are a diverse group, their risks and needs are likely to vary. Thus, it is necessary to identify their varied needs.

In 1989, the state of Maine commissioned a survey of Maine youths who had sexually offended. The objectives of the survey were to determine the number and characteristics of Maine youths who had engaged in sexually abusive behaviors as well as their needs. The survey findings (Righthand, Hennings, & Wigley, 1989) identified over 350 youths who were described as “young sex offenders.” This figure, although high, was considered an underestimate. The results of the survey identified an apparent lack of involvement in sex offense-specific treatment, suggesting that the treatment needs of many of these youths may have gone unmet.

Recognizing the importance of having current information about the risks and needs of Maine youths who have sexually offended, the Maine Departments of Corrections (DOC) and Human Services (DHS) requested that the earlier study be updated and commissioned an in-depth needs and risk assessment project. The goals of the project included completion of a review of the professional literature pertaining to youths who

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have sexually offended; an empirical investigation of Maine youths who have been sexually abusive, their characteristics and treatment and risk management needs; and an assessment of existing treatment programs. Other goals included identifying gaps in service delivery and providing recommendations for developing a continuum of care for these youths. These goals have been accomplished.

This article summarizes the findings of the needs and risk assessment project. It also provides a summary of the empirical investigation of Maine youths who have sexually offended. A more in depth discussion of the findings is available in two companion reports entitled Sex Offending by Maine Youths: Their Offenses and Characteristics: Part I & Part II (Righthand, Welch, Carpenter, Young, & Scoular, 2001).

The empirical investigation was divided into two studies. The first study focused on youths who had open cases in the DOC regardless of whether they had open cases with the DHS. Findings from this study are presented in Part I of Sex Offending by Maine Youths: Their Offenses and Characteristics. The other study focused on youths who had open cases with the DHS, regardless of whether they had open cases with the DOC. Findings from this study are presented in Part II of the report.

As may be apparent from this article, and is clear from a comparison of the full reports, although the topics of the investigation were consistent between studies, specific variables sometimes differed. These differences appeared related to different approaches to record keeping. For example, while the DOC files generally included detailed documentation pertaining to a youth's involvement in the criminal justice system, DHS records were not as strong in this regard. As another example, in contrast to the DOC records, the DHS files tended to have more detailed family history information. These differences in record keeping, and the goal of maximizing the utility of the findings for each state agency, lead to the decision to conduct two separate studies and present the findings in two independent reports.

As a first step in the empirical investigation, DOC and DHS staff independently compiled a list of 302 children and adolescents who appeared to meet the criteria for referral to the research project. They were youths identified as having engaged in sexual behavior with other individuals; behaviors that are described by Maine law as criminal offenses. Fifty-one of the youths had open cases in both departments. When this number was subtracted from the total number to avoid redundancy, the sample size was reduced to 251.

The DOC study included a subset of the 251 youths, 164 youths (153 boys and 11 girls) who had open cases with the Maine DOC during the year beginning June 1, 1997 and who, with the exception of one girl included in the study to increase the sample size for the girls, also had open cases with the DOC at the time of referral to the study. Of the 164 youths, 30% also had open cases with the DHS.

The DHS study also included a subset of the 251 youths, 96 youths (85 boys and 11 girls) who had open cases with DHS during the year under study. This figure was

considered an underestimate of actual cases open with DHS at the time of referral to the study. Of the 96 youths, 53% also had open cases with the Department of Corrections.

To assure that the information provided in the reports would accurately represent the youths and their situations, two independent research assistants collected data from some of the same cases, while remaining unaware of each other's ratings. These ratings were compared and used to evaluate inter-rater reliability. The data included in the reports involved only those variables that were found to be reliable.

Findings indicated that youths who commit sexual offenses still present a significant problem in Maine. The 164 youths in the DOC study were officially charged with more than 280 sexual offenses and, by self-report, admitted to more than 700 additional offenses for which they had not been charged.

The severity of the problem of sexual offending by youths also was evidenced in the DHS sample. Of the 96 identified youths in this sample, over 70% perpetrated acts involving oral-genital contact or attempted or actual vaginal/anal penetration. In addition, more than half of the youths committed multiple sex offenses over a lengthy period (i.e., more than six months). Fortunately, as noted above, research studies have indicated only a relatively small group of youths continue to commit sexual offenses after there has been an official response to their sexual offending. Early and appropriate intervention is of the utmost importance.

The results of the studies described herein are consistent with findings presented in the professional literature that indicate youths who sexually offend are a heterogeneous group. However, certain patterns exist and were present in the Maine sample. These patterns are summarized below.

Both the DOC and DHS studies revealed that these youths frequently experienced family circumstances and relationships that involved loss, conflict, and instability. For example, two-thirds of the youths in the DOC study experienced parental separations through marital separation, divorce, or death. Very few of the youths' developmental years were characterized as involving secure and stable family environments. Nearly a half of the DOC study fathers and a third of the mothers had substance abuse histories.

Similarly, three-fourths of the youths in the DHS sample experienced parental separations through marital separation, divorce, or death. More than half of the DHS study youths experienced multiple changes in caregivers prior to their most serious sexual offense and more than half of their mothers had histories of alcohol or drug abuse (similar data pertaining to the substance abuse histories of the fathers were not reliably available).

In addition, the DOC study findings specifically indicated that, frequently, the youths' relationships with their parents were strained. Parents were described as experiencing substantial difficulty exercising adequate control over their children's "out of control" behaviors. Half of the youths in the study experienced markedly hostile,

indifferent, or uncaring relationships with their fathers (similar data pertaining to relationships with mothers were not reliably available).

The boys and especially the girls in these studies experienced high rates of sexual abuse, physical abuse, and childhood neglect. For example, 58% of the boys and 7 of 8 girls in the DOC study had been sexually abused. Even higher rates of sexual abuse were found in the DHS sample where 71% of the boys and 9 of 10 girls had been sexually abused. Nearly half of the youths in the DOC study and nearly three-quarters of the boys and all of the girls in the DHS sample had been exposed to family violence. The very high rates of child maltreatment among the girls in this sample is consistent with previous research studies that have found higher rates of abuse and trauma among girls who have sexually offended as compared with boys (Mathews, Hunter, & Vuz, 1997, Kubik, Hecker, & Righthand, under review).

The results of these studies also indicated that the problems experienced by these youths extended beyond the home environment to multiple life spheres. For example, in addition to problems at home, difficulties at school were evidenced by high rates of school behavior problems, placement in special classes, truancy, and suspensions or expulsions. Peer relationship problems were substantial and, in half of the DOC cases, were severe and lasting. Seventy percent (70%) of the boys and six of the nine girls in the DOC sample exhibited peer relationship problems, with at least 50% reporting few or no positive friends. Similarly, 83% of the boys and 100% of the girls in the DHS sample exhibited peer relationship problems, with nearly 50% reporting isolation from peers.

In addition, these youths evidenced high rates of generalized conduct problems as indicated by aggression management difficulties, impulsivity, and nonsexual offending. Seventy-five (75%) percent of the boys and four of 10 girls in the DOC study evidenced occasional or frequent physical aggression. Nearly two-thirds of these youths had nonsexual, nonviolent offense histories and over half of the boys (but only 2 of 11 girls) had histories of nonsexual, violent offenses. Also, records indicated that 15% of the boys engaged in cruelty to animals and 27% had histories of fire setting, although only one girl reportedly engaged in fire setting and none were described as having been cruel to animals.

Similarly, findings from the DHS study indicated that 83% of the boys and eight of ten girls engaged in occasional or frequent physical aggression. Also, nearly one-third of the boys engaged in fire setting or cruelty to animals while relatively few of the girls demonstrated these behaviors.

Given these histories, not surprisingly, a substantial number of the youths have significant mental health needs. Forty-two percent (42%) of the boys and 6 of the 11 girls in the DOC study had two or more psychiatric diagnoses. The most common diagnoses for boys were Attention Deficit Hyperactivity Disorder/ Attention Deficit Disorder (ADHD/ADD) (34%) and Conduct Disorder (32%). Five of the eight girls for whom diagnostic information was available had been diagnosed with Post-Traumatic Stress Disorder (PTSD). These high rates of diagnoses far surpass population averages.

Sixty-four percent (64%) of the boys and 5 of the 10 girls in the DHS study had two or more psychiatric diagnoses. Again, the most common psychiatric diagnoses for boys were Attention-Deficit Hyperactivity Disorder/Attention-Deficit Disorder (47%) and Conduct Disorder (44%). Seven of the eight girls for whom diagnostic information was available had been diagnosed with Depression and six of nine were diagnosed with Post-Traumatic Stress Disorder (PTSD). As was true for the DOC sample, these high rates of diagnoses far surpass population averages.

Attitudes and beliefs supportive of sexual offending and criminal behavior were investigated with the DOC sample. Sixty-five percent (65%) of the boys and nine of ten girls demonstrated cognitive distortions as exemplified by attitudes or statements that minimized, distorted, or justified criminal conduct. More than three-quarters of the youths evidenced deficits in remorse or empathy and little or no motivation for change.

In comparison with the 1989 study of Maine youths who sexually offended (Righthand, et al., 1989), results of the current investigation indicated that while juvenile sex offending still presents a significant problem in Maine, gains have been made in the area of assignment to sex offense-specific treatment. Findings indicated that the majority of the youths in this study (76% of the DOC sample and 75% of the DHS sample) appear to have been involved in specialized sex offender treatment since their most recent offense.

This finding appears to be an important improvement. However, the DOC study results reflected high rates of a) cognitive distortions and attitudes and beliefs supportive of criminal behavior; b) impaired empathy and remorse; c) significant family difficulties and social problems; d) substantial academic and school behavior problems; and e) serious emotional and nonsexual behavior problems. The DHS study also reflected similar problems.

In spite of these patterns in the youths' characteristics, behaviors, and clinical presentations, the findings of these studies also indicated that these youths varied from each other in many ways. For example, the youths varied in the frequency of their sexual offending, the duration of their offending, the level of aggression in their offenses, and their involvement in nonsexual offending. They also varied in their child maltreatment histories, and their experiences of family instability and dysfunction. They also differed in their clinical presentations and their range of conduct problems, interpersonal difficulties, and school functioning. These findings are consistent with other studies reported in the professional literature and clearly indicate that a variety of treatment options and interventions are necessary to help youths who have sexually offended develop prosocial and healthy lifestyles.

Studies evaluating the effectiveness of specific interventions designed for children and adolescents who have sexually offended are rare. Important exceptions are the federally funded research of Pithers, Gray, Busconi, and Houchens (1998) and Bonner, Walker, and Berliner (1999), both of which evaluated the effectiveness of outpatient

programs for children with sexually inappropriate or aggressive behaviors. Although these studies did not include untreated children, their findings indicate that treatment interventions generally were effective in reducing sexual behavior problems and sexual offending. Furthermore, Pithers et al. found important group differences. For example, a modified, relapse prevention approach to treatment was more effective than an expressive therapy approach with children classified as “highly traumatized children.” In fact, highly traumatized children who were in the expressive therapy evidenced a slight increase in sexualized behavior. In contrast, the researchers also found that a slightly larger number of the sexually aggressive children in the expressive therapy, compared with those in the modified relapse prevention therapy, evidenced reduced levels of sexual behavior problems. These findings were tempered, however, by the fact that a similar number of the sexually aggressive children in the expressive therapy had increased rates of sexual behavior problems and only 7% of the sexually aggressive children had significant decreases in their sexual behavior problems; findings that suggest these children required additional and possibly varied treatment interventions.

Research (Gendreau & Goggin, 1997) on effective treatment for juveniles and adults who have committed a wide range of crimes, including sexual offenses, has found interventions that target risk factors associated with sex offending and other forms of criminal behavior are more effective than other approaches. The research indicated that effective programs typically are multi-modal and offer a variety of interventions to address a range of needs, especially those that are predictive of future criminal behavior (criminogenic needs) and are dynamic (changeable) in nature such as cognitive distortions, antisocial attitudes, and negative peer associations. Effective treatment approaches were found to emphasize positive reinforcement for prosocial behavior, and were individualized as much as possible. The findings also indicated that to be effective, treatment efforts should be designed in ways that match individual characteristics and learning styles with relevant treatment approaches and therapist characteristics. For example, the special needs of youths with ADHD or with repeated failures in classroom situations should be addressed to facilitate treatment involvement and effectiveness.

In addition, the research on effective treatment programs indicated that the intensity of treatment for moderate and high risk individuals should be of at least 100 hours of direct service over a three- to four-month period and, further, that treatment length of over a year may lead to diminishing returns (Gendreau & Goggin, 1997). The findings also suggested that treatment should be located in the individual’s natural environment, whenever possible. Yet, in order to adequately address the individual and changing needs of youths who have sexually offended, as well as the needs of the community, a continuum of care that provides a range of services is needed (Bengis, 1997; National Adolescent Perpetrator Network, 1993).

Described briefly below are examples of effective intervention approaches (as supported by research) with youths who have engaged in serious delinquent behaviors including sexual offending. However, because youths who sexually offend are a heterogeneous group, it should be remembered that while some youths may require

intensive treatment, some may require minimal interventions once their sexual offending has been disclosed, and still others may need something in between.

Multidimensional Treatment Foster Care (MTFC) is a specialized therapeutic foster care approach that involves placing youths with well-trained and supervised foster families for 6 to 9 months (Chamberlain & Reid, 1998). One of the primary goals of MTFC is breaking delinquent associations and helping youths develop prosocial relationships and values. Typically, when youths are involved in the criminal justice system, only one child is placed in the foster home at a time. Treatment interventions include individual therapy emphasizing prosocial skill development and problem solving. In addition, the youths' behavior is monitored daily, a therapist consults with the foster family each day, and behavior management strategies are revised as needed. Interventions also occur at school as well as with peers. Families of origin or alternative caregivers are very involved in the program and are trained in effective behavior management strategies to facilitate effective parenting when the child goes home. Research studies have found that youths involved in the criminal justice system (including those who have perpetrated sexual offenses) who were randomly assigned to MTFC had significantly fewer criminal referrals and returned home to relatives more often than those in traditional group settings (Chamberlain & Reid).

Multisystemic Treatment (MST) is an empirically based treatment approach that has been shown to be effective with youths in the criminal justice system (Henggeler, Schoenwald, Bourduin, Rowland, & Cunningham, 1998). It also has been empirically validated as effective with juvenile sex offenders (Borduin, Henggeler, Blaske, & Stein, 1990), although the sample size was small in the original study and the comparison treatment did not appear clearly defined. MST involves working with youths and their family over a 6 to 9 month period and confronting antisocial behavior in youths by targeting their "social-ecological context" (i.e., their family, neighborhood, school, and community).

In addition, recent research including youths who have sexually offended has demonstrated that children with significant emotional and behavioral problems can be safely and effectively maintained in the community through specially designed "wraparound" approaches that include natural supports, such as family members or MTFC or similar programs, and a range of needed services. For example, the sex offense recidivism rates of youths enrolled in Wraparound Milwaukee dropped from 11% to 1% after one year of enrollment in the program (Kamradt, 2000).

There is a growing literature base (McMahon & Wells, 1998) suggesting that, particularly for young teenagers (Dishion, 1999), delinquent peer group association, even in a therapeutic context, may have negative effects. It is of the utmost importance that the peer associations of youths who sexually offend, even in the context of a residential placement or group therapies, be managed in ways that reduce exposure to the distorted thinking and delinquent attitudes of others as much as possible. Consistent with this point, it is important to recognize that sex offense-specific therapies that involve group members discussing the specific details of the sexual aspects of their offenses may be

harmful because such discussions may be sexually arousing and/or provide ideas that facilitate or further the development of deviant sexual fantasies.

Maine's ability to adequately respond to the varied risks and needs of youths who sexually offend appears to be hampered by a number of factors. First of all, necessary information for assessing risk and developing risk management interventions is probably not consistently available to the courts, state agencies, and treatment providers as was exemplified during this research's data collection phase. This research project found that the information available in the files varied substantially. Further, inadequate assessment of mental health needs was suggested by the relatively small percentage of youths in the DOC study (a little more than one-third) who received forensic mental health evaluations.

In addition, a review of Maine's sex offense-specific treatment programs (Righthand, 2000) suggested that Maine currently falls short of providing a continuum of care of treatment options and empirically validated interventions. For this program review, existing programs and providers that utilize sex offense-specific group interventions were identified by state agency staff, clinicians, and through the Maine Treatment Directory (Child Abuse Action Network, 2000). It is possible that other existing sex offense-specific treatment programs were not identified by this procedure and clearly there are individual clinicians who provide individual and possibly family therapy to youths who have sexually offended (Child Abuse Action Network).

The findings of the program review (Righthand, 2000) indicated that these treatment providers and programs provide many of the components often recommended for sex offense-specific treatment. However, in contrast to the approaches described above (e.g., Bengis, 1997; Gendreau & Goggin, 1997; National Adolescent Perpetrator Network, 1993), sex offense-specific treatment programs in Maine are limited in number and a range of options is lacking. At the time of the program review, only seven outpatient programs and five residential programs, including the Maine Youth Center's sex offense-specific treatment program, were identified (two other residential programs were in the developmental stages and were not reviewed). The outpatient programs typically consisted of group therapy meetings once a week. Adjunct interventions sometimes were provided, such as parent groups usually held on a monthly basis. Participation in individual therapy in addition to group therapy occasionally was offered or required. Residential programs generally provided long-term treatment and frequently were located in distant geographic locations. Treatment providers identified limited community-based resources and the lack of a continuum of care as a statewide problem.

In sum, study findings indicate that youths who sexually offend do continue to present a significant problem in Maine. Yet, like all youths, they are individuals. They are individuals who present with developmental needs as well as special needs and risks due to their abusive behaviors and troubled lives. Individualized assessment and treatment planning are essential for effective intervention.

As noted elsewhere (Righthand & Welch, 2001), recommended interventions are those that target factors empirically associated with the risk of sexual offending, such as deviant arousal (when present), cognitive distortions, limited social competence, school behavior problems, and aggressive and delinquent behaviors in general (e.g., delinquent peer associations, antisocial attitudes, and impulse and emotion management). Other appropriate targets of intervention include those that appear theoretically relevant, but that researchers have not studied or that research has not shown to be consistently related to risk, such as inadequate dating skills. Still other targets of interventions include problems that may be relevant for individual youths, such as substance abuse, when such problems are present. Risk management strategies that are likely to be most effective are those that target risk factors by addressing related needs and by supporting or facilitating existing strengths. Treatment effectiveness is likely to be increased when interventions are designed and applied in ways that engage the youths and help motivate them to make positive changes in their lives.

Maine lacks a sufficient range of treatment and intervention options for youths who sexually offend. For example, shorter term, intensive multisystemic residential placements are needed, as are other community-based options such as supervised housing, day treatment, after-school programming, intensive outpatient treatment, and a range of outpatient therapies that target criminogenic and related needs. In order to develop a system of care that is responsive to the varied needs of these youths, one that promotes the safety and needs of the community at large, a statewide effort is needed. State and local agencies, private agencies, and private providers will have to work together to develop a continuum and “menu” of care that will meet the needs of individual youths and their communities.

References are listed in Sex Offending by Maine Youths: Their Offenses and Characteristics: Part I & Part II (Righthand, S., Welch, C., Carpenter, E. M., Young, G. S., & Scoular, R. J. 2001). Copies of these reports may be obtained by contacting...

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