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ORIGINAL ARTICLE

Seeking an Integrated Approach to Trauma and Problematic Sexual Behaviors in Adolescents: Learning from Practitioners

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Abstract
More than a third of all sexual crimes are committed by adolescents. In addition, many adolescents struggle with problematic sexual behaviors (PSB) that may not rise to a criminal offense, but cause harm to themselves and those around them. A significant number of these adolescents also have histories of their own trauma; yet there are no treatment models that integrate both PSB and trauma into one comprehensive treatment for this population. This qualitative study's aim was to use the expertise of clinicians who work with adolescents with PSB as well as clients and their caregivers who had completed PSB treatment to understand what they believe are the necessary components and elements needed for an integrated model that seeks to simultaneously address both PSB and the consequences of traumatic experiences. Twenty-six mental health professionals and one former client and his caregiver participated in focus groups (three with clinicians and one with the caregiver and former client) to share their experiences and expertise regarding an integrated model. The thematic analysis procedure yielded six major themes: family, external systems, treatment structure, therapeutic themes, specialized PSB targets, and trauma and PSB integration. Each of these major themes was comprised of subthemes that are presented as well. Implications for practice and future research are discussed, including that clinicians could benefit from guidance and structure to assist them in structuring their interventions to address the multiple needs of their clients that seek to reduce their risk of reoffending while simultaneously enhancing the quality of their lives.

Keywords Trauma · Problematic sexual behavior · Adolescents · Treatment

Seeking an Integrated Approach to Trauma and PSB: Learning from Practitioners

Worldwide, adolescents are responsible for a significant number of sexual abuse cases committed against children and other adolescents; more than one third (35.6%) in the United States (Finkelhor et al., 2009), almost a quarter (22%) in Australia (Shlonsky et al., 2017), and almost two-thirds (65%) in the United Kingdom (Radford et al., 2011). Although sexual recidivism rates for this population remains low (ATSA; Association for the Treatment and Prevention of Sexual Abuse, 2023; Letourneau & Armstrong, 2008) with rates ranging from 3 to 15%, the rates of non-sexual recidivism are considerably higher, as 41% of adolescents with a known sexual offense commit a subsequent non-sexual crime (Caldwell, 2016). In order to reduce rates of both sexual and non-sexual recidivism, effective therapeutic interventions must be available and provided to adolescents with problematic sexual behaviors (PSB-A).

Problematic sexual behaviors by adolescents can include a wide range of inapt sexual expression. At minimum, they can include developmentally inappropriate behaviors, such as "excessive self-stimulation, or other behaviors that do not include the sexual abuse of others" (Malvaso et al., 2020, p. 36). They can also include behaviors that "occur in the

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context of the absence of consent, and which may involve the use of threat of force or force and coercion" (Malvaso et al., 2020, p. 36). In order to reduce PSB-A, effective treatments must target the core drivers (Hekler et al., 2020). Multiple theories have historically been applied to explain the development of PSB and influenced how various treatment programs were developed, including social learning theory, attachment theory, and schema theory (Burton, 2012; Hudson et al., 1999; Hudson & Ward, 2000; Johnston et al., 2009; Leahy, 2015; Marshall et al., 2005; Ward & Keenan, 1999; Ward & Hudson, 2000; Ward & Beech, 2008; Ward, 2014). In recent years, trauma has emerged as one of the most prominent drivers of PSB-A with theoretical frameworks comprehensively integrating trauma elements that account for the impact of adverse experiences that contribute to PSB (Dierkhising et al., 2013; Ford et al., 2007; Grady et al., 2021; Jäggi et al., 2016; Levenson & Grady, 2016; Shivy & Guion, 2012).

Although trauma is now a prominent etiological risk used to understand the development of PSB (Deblinger et al., 2015; Grady et al., 2022b), recent research indicates that clinicians who work with PSB-A struggle to address *both* the PSB and the trauma histories with their clients using their current therapeutic approaches (Yoder & Grady, 2022). Furthermore, adult clients who have attended treatment focused on sexual offending (SOTX) do not perceive that the treatment they received incorporated trauma-informed principles and in fact many reported that they were discouraged from talking about their own trauma histories in SOTX (Grady et al., 2022a, b). The current study's aim was to address this critical gap in knowledge by learning from practitioners who work with PSB-A how they integrate PSB and trauma, with the goal of creating practical guidelines for an integrated treatment for these youth that addresses both critical issues in treatment.

Background Literature

Childhood Adversity and PSB

There is now a large body of research that reports high levels of traumatic events in the lives of adolescents who demonstrate PSB (Burton, 2003; Burton et al., 2011; Grady et al., 2021; Maniglio, 2011; Simons et al., 2008; Yoder et al., 2018, 2019). Many studies indicate that the rates of childhood adversity are significantly higher among these youth compared to the general population, and also compared to youth who commit non-sexual crimes (Baglivio et al., 2014; Levenson et al., 2017a; Seto & Lalumière, 2010; Yoder et al., 2019c). These experiences include different forms of physical, emotional, and/or sexual abuse and/or neglect, witnessing violence, and having parents who are separated, divorced, and/or incarcerated (CDC; Center for Disease Control, 2016). These adverse experiences contribute to numerous negative mental health outcomes, including cognitive and affective regulation, depressive and affective disorders, interpersonal challenges, and post-traumatic stress responses (Burton, 2003; Burton et al., 2016; Seto & Lalumière, 2010; Van Wijk et al., 2006).

To help explain the connection between trauma and PSB, Grady and colleagues (2017) proposed a theoretical model that links adversity with attachment insecurity/interpersonal relationship challenges, which in turn contribute to various risk factors associated with PSB. These include affect and behavioral dysregulation, poor interpersonal relations, and cognitive deficits and/or distortions (Brown & Yoder, 2020; Burton et al., 2016; Grady et al., 2017; Jespersen et al., 2009; Maniglio, 2011; Seto & Lalumière, 2010; Yoder et al., 2019b). Subsequent empirical testing of this model, as well as other research, has provided support that there are strong interactions, both direct and indirect, between different forms of childhood adversity and PSB (Brown & Yoder, 2020; Brown et al., 2022; Grady et al., 2022a; Yoder & Precht, 2020; Yoder et al., 2019a), indicating that while trauma may not be the only contributing factor, it can play a significant role in the development of PSB for some adolescents.

PSB Treatments

It has been widely acknowledged that problem sexual behaviors present a unique challenge for the service delivery sector, given the extensive focus on public safety and motivations to protect communities from sexual violence (Fanniff & Becker, 2006; Kettrey & Lipsey, 2018). As such, treatment and interventions have become a critical intersection for strategies promoting desistence. Historically PSB treatments were not designed to address the clients' own experiences of trauma (Hindman & Peters, 2000). In fact, many clinicians were trained to exclude such topics from treatment focused on sexual offending (SOTX), as it was seen as an "excuse" or as a way to justify their own abusive actions (Grady et al., 2022a; Hindman & Peters, 2000). Unfortunately, as noted previously, recent research with adult clients indicates that some clients are still given this message in SOTX and are discouraged from bringing in their own traumatic histories into their SOTX, even if they are asking to use it to understand some of their current challenges (Grady et al., 2022b; Levenson et al., 2023).

However, there are now some efforts to address trauma in SOTX with both adults(Levenson et al., 2017b; Levenson & Willis, 2019; Levenson, 2020) and especially with children (Allen, 2018; Deblinger et al., 2015; Gomez, 2022). Yet, while trauma specific treatments have been developed

and applied to adults and children, they have not yet been developed or delivered with adolescents, despite the fact that sexual offending peaks during the ages of 13–14 (Finkelhor et al., 2009). Grady et al. (2023) recently published a conceptual paper outlining how Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)(Cohen & Mannarino, 2008; Cohen et al., 2017) could be enhanced to address issues of PSB with adolescents. TF-CBT has been used with children (12 years and under) to address PSB (Allen, 2018; Deblinger et al., 2015), but it has not been formally enhanced to address PSB with adolescents. While Grady and colleagues' recent conceptual paper is a critical step in developing an integrated model of TF-CBT for PSB-A, another important step is to investigate clinical perspectives to identify therapeutic components central to an integrated approach.

Some research has been done on elements of PSB-A treatments that are particularly salient mechanisms in promoting desistance. Treatment targets found to be particularly important have been outlined in the Association for the Treatment of Sexual Abusers (ATSA, 2017, 2023) practice guidelines. These treatment targets include social isolation, attitudes supportive of abuse behavior, caregiver-youth relational experiences, self-regulation, healthy sexuality, social supports, and non-sexual delinquency. One element noted extensively by evidence is the inclusion of family or caregivers in therapeutic processes (Letourneau & Borduin, 2008; Schladale, 2006; Thomas, 2010; Yoder & Ruch, 2016; Yoder & Brown, 2015). In a qualitative study of treatment providers, there were practical strategies noted for how to engage with families that included problem solving, communication skills, "working through the pain", and restructuring and uniting families. In this same study, the therapeutic relationship was noted as a component that was especially powerful in initial engagement and sustained family involvement (Yoder & Ruch, 2016). Nevertheless, despite this knowledge on salient PSB-A treatment elements, these targets fail to integrate trauma in a comprehensive way, despite the field's acknowledgement of trauma as a core driver to the onset and course of PSB-A.

Current Study

This study's aim was to further the development of an integrated model by conducting a qualitative study with PSB-A clinicians about their experiences in addressing both trauma and PSB in treatment. It was also imperative to understand the perspectives of former clients and caregivers (dyads) to determine how needs were addressed within treatment, and thus, this study included the voices of one dyad. Through these collective voices, this study sought to close the gap between conceptual and practical knowledge in order to provide guidance to clinicians working with this complex population. This study was guided by the following research question: How can trauma histories and PSB be mutually addressed within an integrated TF-CBT model?

Method

Procedures

This study employed a qualitative grounded theory methodology (see: Corbin & Strauss, 2008; Kolb, 2012). The study was supported by a small foundation grant and was approved by the Institutional Review Board of the lead author's institution. Participants were recruited from three partner agencies in the United States: two from a southeastern state and one from a western state. The southeastern state agency was a larger statewide juvenile justice system that specifically works with PSB-A, whereas the others were community practice agencies specializing in PSB work and receiving funding that includes self-pay, private insurance, and government-based insurance. All three agencies agreed to participate in the study during the grant submission process and agreed to allocate time for their clinicians to participate in the study. They were identified through the two lead authors' professional networks and signed on as partners prior to the start of the study.

In addition, the research team sought to recruit former clients who had completed some form of SOTX who would be willing to share their experiences with the team. We used professional listservs and our professional contacts, as well as the partner agencies to solicit potential participants. However, only one dyad agreed to participate in the study.

Data Collection

Data were collected through five different focused groups; four with clinicians and one separate meeting with one client and their caregiver. Two different focus groups took place for the outpatient agency in the southeast due to the availability of the clinicians. Each focus group took place via Zoom and was recorded and then transcribed using Otter.ai transcription software. A masters level research assistant then reviewed each transcript while listening to the recording to ensure their accuracy. The focus groups were approximately 1.5 h in length and were organized around a semi-structured interview guide developed by the first two authors. During data collection, memo notes were recorded by the research team and triangulated with the transcripts as part of the data analytic process (see below).

Measures

This interview guide was aimed at answering the overarching research question. As such, the interview questions were aimed at asking the clinicians about their experiences with integrating PSB and trauma work, including the sequencing of clinical topics, how they introduced the topics, the ways that caregivers were integrated into the treatment, and challenges they faced doing this work, as well as what worked. Some example questions included, "In your professional experience, how have you or others integrated trauma practices into treatment?" and "If you had the opportunity to design and develop a trauma-based model for PSB, what would it look like?". The caregiver-youth dyad was asked similar questions but framed to elicit their experiences of the treatment process around these same topic areas.

Data Analysis

Data analysis for this work utilized the constant comparative method(Glaser, 1965; Kolb, 2012; Olson et al., 2016) used in thematic analyses (Braun & Clarke, 2006). The constant comparison method involves analyzing the data within and between the participant interviews (or focus groups) to identify common themes leading to a coding schema after reading and rereading the data. These codes are then used to analyze the data between interview transcripts to identify common themes across the different points of data (Glaser, 1965; Kolb, 2012). In this way, this study employed an inductive grounded theory approach, whereby emergent themes and theoretical concepts were derived from the data. Two masters' students, supervised by the lead author of the study, undertook the analytic process, utilizing Olson et al.'s (2016) 10-step approach for working in teams. Meeting an average of twice monthly, these two coders worked to identify issues and questions, and to resolve any outstanding concerns raised during the analysis process. The coders established a pattern of maintaining reflexivity notes to track their own reactions, thoughts, and ideas about the data collected. The team combined calculating of intercoder reliability (ICR)(Burla et al., 2008) with regular meetings with the supervising researcher to affirm data analysis integrity and trustworthiness. This allowed for regular discussion of data analysis methods and findings as they emerged.

Using Olson and colleagues' 10-step process designed for multiple raters researchers: (1) performed open-coding of data; (2) collaborated to unify codes; (3) re-coded data using unified codes; (4) calculated ICR; (5) collaborated to discuss each code and identified areas lacking agreement; (6) repeated the above process for each segment of the data, producing a unified codebook applicable to all data subsets; (7) re-coded all data, producing themes; (8) selected themes for further analysis; (9) conducted co-occurrence analysis; and (10) constructed an exploratory model – the findings of the study.

For this study, the codes were constructed using the sentences within the transcripts as the unit of analysis. The analytic process used those codes to develop shared conceptual or implicit meaning for the ideas shared by the participants (Braun & Clarke, 2006; Burla et al., 2008). The first round of coding yielded 22 codes, with a ICR scores for the codes ranging from 0.6667 to 1.0. Low ICR scores were explained by imprecise definitions and conceptualizations of terms between coders in the early stages of the process. For example, additional clarification was needed to distinguish between Family Support (with what do the caregivers need in terms of help) versus Family Involvement (how are the family members engaging directly with their child and the treatment process), as those codes were sometimes being coded as the same. Another example was separating family systems and external systems to distinguish between the various external influences impacting the treatment process. After each round of coding, the coders through conference, refined definitions, combined codes, and/or discussed where differences in coding using the unit of analysis may have occurred. This process took place over four subsequent rounds of coding, until all of the codes reached an ICR score of 85% or higher. The final ICR range was 0.8571 to 1.0.

Rigor and trustworthiness were address using several different methods. First, the data were triangulated from using the dyads and from the clinicians from several different agencies. Second, multiple coders were used during the coding process to reduce bias, which also included calculating the ICR. Third, we did member checking during the interview process and asked participants for the ability to follow up later for clarification. Fourth, memos were creating during the interviews, which were used to support the themes that emerged during the analytic processes. Finally, reflexivity journals were maintained, paired with team conferences aimed at identifying any biases and challenges that emerged during the analytic processes.

Results

Participants

The participants were primarily mental health professionals who work in with adolescents with PSB. They were drawn from three different organizations; one was from an outpatient agency in a western state, another from an outpatient agency in a southern state, and a third from a youth development treatment facility based within a state's juvenile justice residential rehabilitation center in a southern

state. In addition, there was one mother/son dyad. The mental health professionals were sent a separate survey asking them to provide their profession, years of experience, gender identity, and racial identity. Nineteen of the 26 participants completed the survey. Of those, nine were clinical social workers, three were psychologists, four were licensed/qualified professional counselors, and three identified as a sex offender treatment counselor or coordinator. Their years of experience ranged from one to 27 years, with the average number being 10.26 ($SD = 7.97$). There were four males and 15 females and four identified as Black/African Descent, two as Hispanic/Latinx, and 13 identified as White/Caucasian.

Qualitative Results

The data analysis process yielded six major themes with some of the themes having subthemes within them. See Table 1 for the frequencies for each of the major themes. In the following section, the primary themes are described with quotes integrated into the description aimed to answer the study's research question: How can trauma histories and PSB be mutually addressed within an integrated TF-CBT model?

Family

Participants in the focus groups frequently highlighted the importance of family participation, support, and education in the treatment process, citing it as a "core component" of a successful treatment program. Acknowledgement of the barriers created by family systems as well as the potential need to address historical trauma within the unit were repeatedly noted as challenges. Within the larger umbrella of family themes discussed, researchers coded for family involvement, family education, family support, family trauma and the family system.

Importance of Family Involvement

This code was defined as family participation in the treatment process and integration of the youth back into the family unit. Several noted the importance of parental and family support. "I view the parents as a way, as a guide, to help the treatment process because we all know if the parents are not bought in, the child's not gonna buy in." Clinicians reported experiencing "great success" when parents and caregivers were involved, stating "it really makes a huge difference to have a support system." Early participation in the treatment process from caregivers was linked to an overall increase in program involvement, "I know I run into barriers with trying to get parents participation later on when we haven't been participating the whole time." Also, noted was that a lack of participation from parents or caregivers was noted as one of the most challenging aspects of treating youth with problematic sexual behaviors, commenting "we didn't have caregivers to include in therapy…you could see the devastation and the trauma…of not having an adult to participate in your treatment." For youth involved in the juvenile justice system, clinicians noted an increased need to provide parent education on problematic sexual behaviors.

> I find that a lot of the parents of my JSOs have just as many, if not more, thinking errors about whatever the allegations are, then the kid does…And so I find that it's a lot less likely to have parents who are willing to participate and be engaged in treatment…if their kid's being required to come…because they've been alleged to do something…it's much more likely for them to kind of just drop the kid off…it's a lot harder to get those parents engaged.

During the caregiver-youth dyad interview, the youth expanded upon these concepts further and attributed his ability to successfully navigate the treatment process to the support received from family and friends stating,

> The fact that my friends and my family supported me throughout all of it and challenged me and didn't let me just sulk or anything like that, that they pushed me to be the absolute best that I could be, and remind myself of what I'm doing this for. That is the reason why I was able to keep going. Because if I didn't have that support, I would have just wallowed in self-pity and just given up on trying, and I would have just failed both the program and everything else that I was doing in life.

Parent and Family Education

Family knowledge of sexual abuse, both the offending behaviors and the role of trauma in their child's development was also an important theme. Clinicians perceived a need to provide parents education on childhood trauma, the various ways an individual responds to trauma, how it contributes to the child's "acting out," and educating on the role of the family system in the treatment process. "The thing about teenagers is they're still in the home…it would be helpful to educate parents…about how the environment's affecting their child." Clinicians expressed a belief that educating parents and caregivers on the phases of treatment and problematic sexual behaviors would reduce the stigmas with which families are approaching the process.

Table 1 Summary of themes and frequencies

Theme	Definition	n
Family Themes		
Family Involvement	The importance of and need for participation and engagement of family in the treatment process and for client integration back into the family	32
Parent/Family Education	Family knowledge of sexual abuse, both offending and the role of trauma in their child's development	23
Parent/Family Support	The level of support the family members have or need during the treatment process and beyond	19
Family Trauma	Supporting the family when they are reminded of their own traumas and recognizing the traumas of being involved in the system	9
Family Systems	When the structure of the family systems creates challenges or barriers for treatment	12
External Systems		
System challenges	How the systems surrounding the client create barriers that limit approaches to the work. This includes insurance requirements, treatment settings, funding, etc.	32
Legal challenges	Involvement with the legal system, including, but not limited to mandated reporting, adjudication, and engagement with parole officers	16
Treatment Structure		
Manual	The use of manual curriculums during treatment or the decision not to use these manuals if they are not relevant or lack information	29
Modality	What modalities do clinicians choose to utilize given the environment, client, and circumstances	21
Flexibility	The need for clinicians to be flexible in the treatment process and to be able to individualize the treatment for each client's needs and circumstances	29
Order	How clinicians decide to order PSB and trauma work throughout the treatment process	34
Therapeutic Themes		
Therapeutic relationships	The importance of the relationship between client and clinician	8
Client engagement	The need for client's "buy in" for treatment and their participation in the process	13
Trauma and PBS Integration		
Exposure to trauma work	When and how trauma work is used by a clinician during treatment	52
Connection of trauma and offending actions	The importance of clients understanding the connection between trauma and PSB and having their experiences validated	47
PSB-Specific Treatment Targets		
Porn	The impact of pornography on clients and the need for education regarding access, internet safety, and environmental messaging	5
Stigma	The internal and external judgment and stigma that clients receive and the language that is used towards clients with PSB	18
Cognitive restructuring	The importance of clients' understanding of the thinking patterns, thought errors, and triggers in relation to their actions	28
Psychoeducation	Informing clients on sex education, trauma memories, consent, sexting, and illegal sexual behaviors	32
Victim Empathy	Understanding the experience of a victim for both the victims of clients and clients who were victims themselves– empathy for self as the abused and the need to understand the harm they caused as the abuser	10
Accountability	The need for clients to take responsibility for their actions and the tension for clinicians between promoting responsibility and recognizing the client's own trauma	21
Continuum of care	The concern for clients' progress when they are no longer in intensive treatment	19
Safety	Maintaining safety for clients, families, and other minors	19
Protective Factors	The importance of supportive relationships and access to resources	2

One therapist observed, "It might be as simple as asking the parents why they don't want to participate…Because, you know, you may find that they have…a skewed view on juvenile sex offenders. And maybe all it would take is a little bit of education." Clinicians noted a need for "more tangible tools" and resources to help parents plan for life beyond treatment and system involvement, the skills to continue discussing sexual development, and gender identity, and the ability to "not only intervene but to recognize grooming and abusive behaviors."

Parent and Family Support

Another important aspect was the level of support family members have access to during the treatment process and beyond. The caregiver shared the experience of having a

lack of family support throughout the process, which can lead to families feeling overwhelmed as they attempt to successfully navigate treatment.

> There were so many of the families in the support groups that I went to that they were just alone. It was just them there, and they were the ones taking care of it all. They're taking care of, you know, grandkids and trying to do this, and this and this, and their just at the end of their rope, and, you know, they break down and that took because they didn't, they didn't know how long that they could hold on and keep going and keep doing it all.

Clinicians echoed this sentiment, indicating that support networks for parents involved in the treatment process for youth with PSB was a gap and that it "would be really beneficial" as this gap contributed to "isolation" and limited the ability for family members to share resources with each other.

Family Trauma

The code of family trauma emerged when there was a discussion about the importance of supporting the family when they are reminded of their own traumas as well as the traumas of being involved in the system. Clinicians noted family trauma often came up during treatment but pointed to limitations in existing interventions for working directly with families to process their own traumatic experiences. Additionally, family members and loved ones may experience vicarious trauma during and after the treatment process. The caregiver remarked, "I lost my entire family over this" when she discussed the shame, the stress, and then tension that emerged within her family after the disclosure of the offense.

Family Systems

The family systems theme focused on how different family systems and/or structures had an impact on the treatment process. Clinicians remarked that not all home systems will provide supportive environments for the process, stating "many of our kids are still living in really dysfunctional family environments. And so, a lot of that, like verbal abuse, physical abuse, things like that is still going on." Clinicians commented on difficulties that arise when the parent has abused the youth receiving treatment for problematic sexual behaviors.

> There could be, or has been a parent that has abused their child. And then that child has gone on to, you know, display some problem sexual behaviors, and it has never really been held accountable. Or like that parent is just kind of not involved at all, or somehow sidestepped their own legal accountability and all that. But oftentimes, we have like, say, like a sibling of that youth, or a step sibling, or some extended family member, and they were able to sidestep again, legal ramifications. And then our youth were who were working through with the PSB model never received that accountability or didn't see that person go through this treatment themselves, or like, why am I stuck doing all this hard work when the person who abused me never had to do any of this stuff?

Individuals noted the use of trauma narratives in helping youth navigate challenging family systems have been useful during treatment.

> I think back to a client where they experienced a lot of abuse from, emotional abuse, from their parents…the way they were treated was a big contributing factor to…how they acted out sexually. And so we started talking about how they, we started processing…I had him write a letter to himself of what he wished his dad and stepmom would say to him and how they would apologize and take accountability for some of their actions. Because he, one, didn't want anything to do with them, and two, didn't believe that they would ever take accountability for that. So, I had him write his own trauma narrative in that sense.

External Systems

In addition to the family system, the larger system in which the interventions took place was a consistent theme that emerged, specifically regarding the challenges and barriers that limited the ability to focus on trauma work. The factors within this larger system included, but were not limited to, mandated reporting, adjudication, and engagement with parole officers. These included financial issues, such insurance requirements and expenses, but also challenges related to the treatment settings and the clinicians' lack of knowledge and understanding pertaining to PSB-A and trauma. One clinician described the following scenario she experienced in a community-based agency setting, "I was told that they can go to a trauma therapist, and they can be referred out for that and that what we were focusing on was their sexual behavior issues and not on their past trauma." Several of the participants noted the challenges that families faced in trying to get services simultaneously for *both* their child's trauma and PSB. For example, the caregiver noted

that both parents had to take on second jobs to pay for the "trauma" treatments, which were separate from those mandated by the court, which only focused on PSB.

> I kept saying…at what point can we address him as the victim? Where is that in the process? And we were told, 'Well, that won't be part of this process. It's not what the courts want…' and I kept saying, why are we not addressing this in any way? And she said, that's just not the way the program works.

These struggles to educate professionals about the needs of these youth extended beyond clinicians and included other professionals as well. One participant noted that this involved "not just educating folks in the mental health field, but also educating law enforcement and doing joint sessions. I've done a lot of trainings with law enforcement, with officers, and I find it to be so, so fruitful, because you get to see like how people are thinking differently, and the angles people are coming at."

Treatment Structure

The clinicians also discussed how they structured the treatment that they provided to youth with PSB and trauma. Clinicians, caregiver and youth all echoed the challenges conducting PSB work due to the offense-specific model, noting "some of the other work kind of gets pushed to the wayside" because "so much of the focus does have to be on making sure they're not reoffending…the trauma part is not necessarily as much of a focus." Although some mentioned using certain manuals, most of the clinicians frequently referenced a need for flexibility to individualize therapy based on a client's specific needs, as well as potential legal requirements. Many reported using an integrative approach, pulling aspects and modules from multiple manuals and theoretical perspectives. However, they did not report having a specific structure to help them navigate this clinical decision-making process. These clinical decisions regarding when to introduce trauma work was determined by a variety of factors, often the legal system, family understanding and willingness to engage in the work, as well as client engagement and disclosure of a trauma history. "Sometimes our kids even feel traumatized by the system. And they feel forced to do these things…they're just super resistant and not even willing to go there with us. And so sometimes it's just planting a seed and saying, 'We hope someday you'll address this somewhere in your life, when you're ready'."

Therapeutic Themes

It was clear that many clinicians felt that a core component of their work with these youth centered on the quality of the therapeutic relationship. One clinician noted the therapeutic relationship as the foundational aspect of work with PSB stating, "I think for clients to be able to talk honestly about what they did, and to not be seen as a monster and to be accepted and not kicked out of the space and to still be held within tight boundaries– I think is really essential, especially for kids that are coming from their own trauma background or from homes in which they're fearful of repercussions or consequences." The youth echoed that statement saying, "there's no way I would have completed it successfully, if the therapist and my entire team didn't truly believe that I was where I was supposed to be within the program and how it actually made progress."

Being able to gain the client's trust and engage them in the therapeutic process or "buy in" was noted as a challenge by the clinicians who shared that "My SAI [sexually aggressive individual] cases are clients who don't want to be in therapy, but are required to and I think that is where that difference of what someone is ready and willing to participate in, really comes out." In order to increase their engagement, many clinicians reported that they needed to respect the client's autonomy in dealing with their own trauma history and the importance of "addressing it [the trauma] when and how they're ready to."

Specialized PSB-A Targets

Focus group participants noted important components of treatment that were not related specifically to a client's trauma, but they felt critical to consider. These topics included: pornography, stigma, cognitive restructuring, psychoeducation, victim empathy, accountability, sustainability, safety, and protective factors should all be discussed within the treatment. These areas were more of a focus in the PSB phase of the treatment.

Pornography

This code was defined as the impact of pornography on youth and the need for education regarding access and environmental messaging. Pornography was described by some clinicians as a "driving force" that contributed both to youth's "sexual preoccupation" and their risk for reoffending. One participant attributed pornography use to the cognitive "distortions" that the youth demonstrate due to the fact that "these youth that we're treating today have basically received their sex education from pornography." The unrealistic and violent material that the youth see through

pornography comes "critical time of sexual development," compounding its negative effects on the youth.

Stigma

The internal and external judgment and stigma that clients receive was consistently highlighted by focus group participants. Clinicians noted that there is generally a "skewed view on juvenile sex offenders" that focuses solely on a youth's PSB. When describing how youth engaging in PSB are depicted, one youth participant shared that,

> Especially in this day and age, anytime you see any news article, any news story, that people who have offended are painted as absolutely horrible monsters who deserve to die or rot in jail. And that's all that I ever see. I never see any other stories you don't see, oh, this person who did this in their past, is now correcting their mistakes and moving forward (with) their lives and making amends.

Clinicians noted that they felt that some of the available treatment materials further perpetuate stigma through the language that is used within the manuals.

> I just don't always like that language because I feel like a lot of our kids already are very shameful of themselves. And, shame isn't the goal that we're trying to address. It's not what we're wanting them to feel.

As a result, some clinicians reported that they either modified the available manuals themselves, or chose not to include certain parts due to these concerns.

Cognitive Restructuring

The clinicians noted how important it was for the youth to understand their thinking patterns, thought errors, and cues that prompted a particular action. Clinicians noted that cognitive distortions and distorted thought patterns affect youth's general "mental health, self-esteem, and functioning" in addition to their "offending behaviors." Working on cognitive restructuring was considered by many participants as "essential" because if youth "can't identify their emotions and express them, that's going to cause them problems." Cognitive restructuring included identifying distorted thinking and teaching youth how "if they don't really address those thoughts, how that might impact their behaviors, and potentially lead them down the path of doing something unsafe." When youth are "able to recognize when they themselves are displaying (thinking errors)", they are then able to learn "healthy coping skills and healthy ways of meeting their emotional needs." For some clinicians, they identified this unit as being the most important in their PSB curriculum.

For the youth, understanding the connection between thoughts, feelings, and behaviors was "incredibly valuable" and allowed them to understand the patterns their behaviors existed in.

> So when you see a thought and the feeling and then a behavior, like where in the cycle could be triggers for you that could then bring you back into that problematic sexual behavior? And how can what can we do to not let you get to that point? I think that that for me, that was the biggest thing of just understanding my own personal cycle… And those, just those two ideas just helped throughout the entire curriculum of trying to make sure that I don't go back into that place again. And if I do get to that point, what can I do to correct that?

Psychoeducation

The participants also stated that psychoeducation was a critical element of the treatment process, as they learn about concepts like "boundaries, consent, healthy and unhealthy relationships," as well as sex education. Participating clinicians noted that psychoeducation is necessary for "clearing up and addressing all those myths and misconceptions around sex and sexuality." Participants also highlighted how psychoeducation was also utilized to teach youth about the physical and mental impacts of trauma, both for themselves and for the person/people that they hurt through their own actions. They also noted that helping youth better understand trauma responses and how trauma affects the brain/nervous system is critical for helping youth to "understand why they act out" and begin learning how to regulate themselves.

Victim Empathy

Victim empathy was defined as youth understanding the experience of a victim and how problematic sexual behavior impacted them and many described that they placed the "biggest emphasis" on this unit in offense-specific treatment. Participating clinicians also noted that clients who have experienced their own trauma often need to experience empathy for their experiences in order to better empathize with victims. For example, one clinician discussed how they talk about this with clients.

> You're telling me you felt this way, when you were victimized, you know, imagine how the child that you molested, felt… (I) try to then tie it around so that they can see…if they can develop some empathy for themselves and their own experience, and get in touch with those feelings, then maybe they can use that to better understand, you know, how their victim felt.

Accountability

Accountability was defined as the need for clients to take responsibility for their actions, while simultaneously recognizing that there is a tension between promoting responsibility and recognizing the client's own trauma. The participants noted that it was essential for their clients to take responsibility, by acknowledging the offense that was committed and the impact and effects that their actions had on others. This tension was summarized by one participant who shared,

> I think for clinicians that can be tough to balance, holding youth accountable and giving them space to understand their own trauma, without it seeming like an excuse, or like a minimization or things like that.

They said holding this tension can be particularly challenging for youth who "never received accountability from their own abuser or whoever hurt them in the past."

Continuum of Care

Concerns for clients' progress when they were no longer in intensive treatment and the sustainability of treatment were shared in focus groups. Relapse prevention work was noted by participants as a way of "trying to make sure that our clients are set up for success once they complete treatment." This theme really focused on the need for their clients to maintain the gains that they had established while in treatment.

Safety

Safety was coded when the participants discussed maintaining safety for clients, families, and other minors during and after treatment. Participants discussed the importance of safety plans that assess situations that might put them and others at risk, as well as providing them with available resources that can serve as supports to mitigate these risks. Many of the participants noted that safety was a consistent theme in treatment, as "so much of the focus (of treatment) does have to be on making sure that they're not reoffending."

Some of the challenges surrounding safety included when a youth is living in the home with younger children or at times is still living with the person that they hurt, and the need to balance safety concerns with the need for youth to socialize and develop healthy social skills. One clinician explained that

> It's kind of a tightrope because you want these kids to be socializing, you want these kids to be doing things in the community that are healthy. But a lot of programs don't want them given their history or problematic sexual behaviors. And then we also have to make sure that whatever they are participating in is heavily supervised so that we're not risking other kids being victimized. So finding… an appropriate, prosocial something that's going to meet all of those needs, that they're going to be able to be involved in consistently, is really important.

Protective Factors

Participants also explained the importance of protective factors, especially having supportive relationships and access to financial and therapeutic resources. Youth and caregiver participants noted that having family and friends who were supportive of the youth was vital to the youth's successful treatment, noting they both did not know how youth without "any sort of support system" "possibly could have made their way through (treatment)." When reflecting on the importance of supportive relationships, the youth participant shared,

> Hands down if I didn't have the family that I have. And then also the friends that I had up there that I disclosed everything to and had that support, I would not have made it. I easily would have failed out of the program.
>
> Participating clinicians also noted the importance of identifying and building upon protective factors during treatment, as having and/or lacking protective factors is its own "treatment issue."

Trauma and PSB Integration

When discussing trauma and incorporating trauma work into the PSB treatment, the participants discussed two main themes: exposure to trauma work and connection of trauma and offending actions. Exposure to trauma work refers to when and how to integrate the youth's own trauma experiences into the treatment process. Connection of trauma and

offending actions describes the importance of clients understanding the relationships between their trauma and their PSB.

Exposure to Trauma

The timing of when to include the trauma work in PSB treatment was particularly challenging for the practitioners, as they discussed the need to consider "where the youth is at in terms of their willingness and readiness." Several participants say they try to "address the trauma as soon as it comes up… to the degree that (they) think the client can handle it." However, among the practitioners, including those within the same agency, there was a great deal of variety in when and how the clinicians addressed the youth's own trauma. Some felt that the clients who are experiencing high degrees of shame and defensiveness around their PSB benefit from exploring their trauma first in order to be more open to future PSB work. Others felt that for youth who may not be ready to begin unpacking their own trauma, participants aimed to give youth "gradual exposure" to the concept of trauma. When they did address it, some shared that they used a particular curriculum that covered trauma or models of intervention, including TF-CBT. Others described using a youth's life timeline/narrative as a way to begin discussing trauma. Again, there was a great deal of variation among how and when this process was done.

The youth reported that in their SOTX they were not "allowed" to address or talk about their own trauma and was told that this topic was to be addressed in a separate treatment, rather than being integrated into the SOTX. For the youth and their caregiver, they felt that this lack of willingness and/or ability to address both issues simultaneously was the biggest gap in their treatment, sharing that "a lot of people have their own trauma even if they haven't talked about it, they have probably felt it and experienced it."

Connection of Trauma and Offending Actions

Regardless of when and how the youth's trauma is processed, the participants strongly emphasized the importance of the youth understanding the connection between their trauma histories and their current PSB. Often, they felt that this process needed to begin with validating the clients' own traumatic experiences, as this can help to get "really good client buy-in" and treatment "becomes a lot easier" because they "feel like they're being treated as a whole person." For the youth participant, they shared that understanding this connection was when they began to "thrive" in treatment. As this work had to be done separately from the PSB work, the youth reported that they struggled within the PSB treatment initially because this connection was not discussed.

> For me, it was just damaging from the get go because I didn't even my brain didn't even know what to think. Because I didn't get the chance to even truly understand what happened to me first before talking about what I had done wrong. And I feel like it would have just been more helpful from the get go to get that just space to talk about my own victimization, and then start addressing how I victimized others.

Participating clinicians shared similar experiences about not having "enough focus on the way that their (trauma) abuse impacts how they interact with people and how it impacts their decision making." Instead, they shared that they feel that existing treatment models and programs have "more of a focus on what you did as opposed to how what happened to you contributes to what you did." When discussing how to build the connection between trauma and PSB in treatment, participants reiterated that it is a "balancing act" between addressing a "youth's victimization…while still holding them accountable for victimizing others."

Discussion

Summary of Findings

The findings of this study indicate that there are a number of challenges to integrating PSB focused treatment along with the youths' own history of trauma. The six major themes that emerged were family, external systems, structure, therapeutic themes, non-trauma specific themes, and trauma and PSB integration. While there was a great deal of consistency around the challenges that the participants noted in this work, how they chose to address these challenges and provide an integrated treatment varied considerably. There appears to be little consensus among the practitioners with regards to how and when integration should occur, including those clinicians who work within the same agency. As such, each clinician was creating their own roadmap for this work and not relying on an evidence-driven protocol or guidelines to inform the work.

Implications for Practice

This lack of consistency among the participants emphasizes the need for clear but flexibly guidelines to help clinicians navigate this challenging treatment. Clinicians who work with other youth populations with complex needs report how important it is to have a therapeutic approach that has a clear structure, yet also offers flexibility, which allows them to tailor the treatment to the needs of their clients (Chorpita et al., 2014, 2015). Such guidelines for this integrated

treatment should include decision-trees that help clinicians to determine the timing of when to begin to process their treatment and what material they may want to emphasize over others.

Given that clinicians who primarily work with PSB appear to struggle with providing treatments that are trauma-informed and/or include trauma-based treatments (Grady et al., 2022b), an important first step would be to offer more trainings on these topics for PSB-oriented clinicians. Trauma-focused treatments could include TF-CBT (Cohen & Mannarino, 2008; Cohen et al., 2017), Eye-Movement and Desentization therapy (Shapiro, 2002, 2017), Cognitive Processing Therapy (Chard, 2005), Narrative exposure therapy (NET) for forensic offender rehabilitation (FORNET) (Hecker et al., 2015), and Prolonged Exposure Therapy (Foa, 2011). Although none of these have been specifically designed for or tested with adolescents with PSB, Grady and colleagues (2023) recent conceptual framework provides a good starting point.

At a minimum, clinicians should seek to provide trauma-informed care (TIC) within their agencies and practices (SAMHSA; Substance Abuse and Mental Health Services Administration, 2014). TIC is a universal approach to providing care to all clients that adheres to six guiding principles: (1) Safety; (2) Trustworthiness and Transparency; (3) Peer Support; (4) Collaboration and Mutuality; (5) Empowerment, Voice, and Choice; and (6) Cultural, Historical, and Gender Responsiveness (SAHMSA, 2014). It does not seek to treat trauma, but rather encourages service providers to provide a context in which they feel heard, validated, safe, and respected (Levenson et al., 2017b; Levenson & Willis, 2019; Levenson, 2020). TIC practitioners highlight the clients' strengths and shift from a pathologizing stance of "What's wrong with you?" to one that explores "What happened to you?" to destigmatize behaviors and understand them as serving as coping skills as a form of adaptation (Bloom & Farragher, 2013).

Implications for Research

The results from this study offer many new and exciting pathways for researcher pursuits. Principally, research is on the horizon for the development and testing of the first fully integrated trauma model for adolescents. While there is recognition of the approaches that have integrated trauma elements in PSB-A work, a model like TF-CBT for PSB-A can be of utility for clinicians who seek greater tools and guided steps for full integration. Researchers can begin to test this model for effects on proximal and distal outcomes. In specifically evaluating proximal outcomes, researchers may consider testing the triangulated impacts of treatment targets within a dual model of TF-CBT for PSB-A (i.e., trauma symptom reduction, caregiver-youth dyadic relations, or emotional and behavioral regulation). Improvements in such proximal indicators may reflect the therapeutic benefit of TF-CBT, and, with ongoing caregiver support, they may be sustainable over time to reduce sexual or non-sexual recidivism.

Given that our sample was clinicians was derived from both community practice and facility-based juvenile justice settings, research also needs to be done on the setting-level factors that influence implementation of TF-CBT for PSB-A. While more and more youth are receiving community-based alternatives and are actively being deferred from juvenile justice processes, as of 2010, about 26% of the total programs treating male PSB-A in the US are facility based (McGrath et al., 2010). Facility-based treatment may always be a viable option for youth with higher risk levels or for youth with dual-system involvement (child welfare and juvenile justice). Thus, implementation research that considers real-world conditions and variable factors including availability of caregivers, court oversight, controlled milieu conditions, risk-level, or telehealth delivery are necessary to inform any effectiveness trial.

Limitations

It is important to consider the findings of this study in the context of its limitations. One of these is that because this is a qualitative study, the findings cannot be generalized to all practitioners who work with adolescents who struggle with PSB. In addition, the participants of this study were expressing their own opinions based on their experience, rather than evidence they have gathered regarding their practices/interventions. Also, although we sought to recruit other youth and caregivers to share their experiences, we were only able to recruit one dyad, which limited this important perspective regarding research question. The reports from the clinicians and dyad influenced the themes, but there could be additional themes, not captured through the analytic process that could have been explored. While qualitative rigor was upheld in this study, one limitation is that researchers who collected the data were also some of the same researchers who coded and analyzed the data. It would be important to explore a more diverse sample of clinicians who work in various pockets across the country including different geographic regions across the country to determine how differential or similar results may be found in differing diverse settings.

Conclusion

The findings of this study demonstrate that clinicians who work with adolescents with PSB struggle with how, when, and in what ways to integrate their clients' own personal trauma(s) and those they have inflicted onto others. While many of the same treatment targets address both trauma and PSB, such as affect regulation and safety, larger systemic issues, such as the involvement of the criminal justice system is unique to this population and can have a significant impact on the treatment process. Clinicians could benefit from having additional guidance and structure to assist them in consistently structuring their interventions to provide an intervention that addresses the multiple needs of their clients that seek to reduce their risk of reoffending while simultaneously enhancing the quality of their lives.

Declarations

Conflict of Interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

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