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Trauma, criminalization, and movements for healing justice : a theoretical study of relational theory and transformative justice interventions in the treatment of juvenile sexual offending

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ABSTRACT

This theoretical thesis explores the etiology and treatment of juvenile sexual offenders from the perspectives of psychoanalytic relational theory and the emerging grassroots theory of transformative justice, drawing together the often-disconnected spheres of the individual and the systemic in the study and treatment of child sexual abuse. This study traces the concepts of *dissociation* and *reenactment* to examine the role of unconscious traumatogenic phenomena and the apparent parallel process across the individual and systemic dimensions of juvenile sexual offending. Engaging two theories from outside the mainstream treatment model, this study asks what clinical understandings and treatment possibilities may be foreclosed by the prevailing paradigm, and how these alternate perspectives may promote healing and long-term prevention of the replication of trauma and abuse. Finally, a case vignette is discussed and implications for clinical practice and future research are explored.

TRAUMA, CRIMINALIZATION, AND MOVEMENTS FOR HEALING JUSTICE: A THEORETICAL STUDY OF RELATIONAL THEORY AND TRANSFORMATIVE JUSTICE INTERVENTIONS IN THE TREATMENT OF JUVENILE SEXUAL OFFENDING

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As Andrea Smith writes in the introduction to *Conquest* (2005), analysis is always the product of group effort and struggle. All oversights, misinterpretations, and errors are mine. The politics that shape this study, however, originate and live in the ongoing collective work of movements for liberation.

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CHAPTER ONE

INTRODUCTION

> [F]or children in an abusive environment there is greater psychological danger if they allow themselves to experience fully their own victimization. Far more conducive to self-protection, at least in the short term, is the defence of identification with the aggressor (Anna Freud, 1936). The trauma remains, but in split off form both within and also *not* within the self. The abused self is not allowed to become conscious (Woods, 1997, p. 382).

> The patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out. He reproduces it not as a memory but as an action, he *repeats* it without of course, knowing that he is repeating it. . . . Above all, the patient will *begin* his treatment with a repetition of this kind (Freud, S., 1914, p. 150).

In no small part, the field of psychotherapy originated in a recognition, however brief, of both the profound impact of child sexual abuse on the psyche of individual victims, and the shockingly widespread nature of the social epidemic throughout communities. Within 18 months of introducing his "seduction theory"—a clinically driven theory of the pathognomic role of childhood sexual trauma in the genesis of what was then known as "hysteria" in adulthood—Freud rejected this theory and went on to emphasize the Oedipal complex and the role of unconscious fantasy, rather than actual traumatic experience, in the etiology of neuroses (Davies & Frawley, 1994).[1] Differing perspectives on the meaning of child sexual abuse (CSA) are, in some ways, at the heart of foundational theoretical debates within psychoanalysis, creating historic fissures and also propelling the theory forward. Hungarian analyst Sandor Ferenczi's

[1] Germinal trauma theorist Judith Herman (1992) has drawn attention to the political and social context surrounding Freud's famous renunciation, contrasting the reception of Freud's post-seduction theory with that of his contemporary, Pierre Janet, whose traumatic theory of hysteria was marginalized by the psychoanalytic community of his day. Herman (1992) emphasizes the intertwined nature of the political and the private, and the essential role of social movements in creating and sustaining the political and social conditions necessary to advance the study of trauma. (See also, Whittier, 2009 for an extensive discussion of social movements and counter-movements and the politics of CSA).

dissenting trauma theory led to his excommunication from the psychoanalytic community and the field's abandonment of his ideas for much of the 20th century.[2] Feminists and others within and outside the psychoanalytic tradition have described such historic tendencies as a systemic parallel process, noting that such ruptures and alternating dissociative responses at the social scale echo common responses to the epidemic of CSA among individuals and within families (Herman, 1992; Stein, 2011).

Though there has been progress in understanding the impact of trauma on individuals, and in the treatment of individuals who have survived traumatic experiences, rates of CSA remain largely consistent (Bolen & Scannapieco, 1999; Putnam, 2003). A meta-analysis of existing prevalence studies (of North American populations) estimates the lifetime prevalence of child sexual abuse for girls to be between 30 and 40 percent and at least 13 percent for boys (Bolen & Scannapieco, 1999). Estimates are consistent across racial and socioeconomic groupings, and globally; meta-analyses of global epidemiological data show rates of child sexual abuse consistent with reported data in the US (Finkelhor, 1993, 1994a & 1994b; Putnam, 2003). While clinicians are beginning to learn how to treat individuals with histories of trauma (Allen, 2001; Herman, 2008), interventions are largely implemented long after the original harm has occurred. Historically, the clinical literature has been less focused on proactively attempting to intervene into the cycle of intergenerational abuse. There has been little research that has specifically explored the intergenerational nature of CSA (Putnam, 2003).

An under-examined aspect of child sexual abuse is the fact that a significant percentage of sexual offenders are themselves children or adolescents (Finkelhor, 2009; Lowenstein, 2006, Vizard, 2013). Synthesizing data from several studies and meta-analyses, Vizard (2013)

[2] See Palmer and Meyer (1995) for a discussion of the historic rupture between Freud and Ferenczi, central to which was Ferenczi's challenge to Freud's recantation of his seduction theory.

estimates the prevalence of CSA perpetrated by children and adolescents to be between 20 and 50 percent of all CSA. The majority of juvenile sex offenders are themselves survivors of sexual abuse, physical abuse or neglect (Lowenstein, 2006; Woods, 1997). Research and practice into ending child sexual abuse then, can be greatly served through the examination of the behavior and treatment of juvenile sexual abusers.

The purpose of this study is to draw together the often-disconnected spheres of the individual and the social in the study and treatment of intimate violence. Specifically, this study focuses on the phenomenon of juvenile sexual abusers in the larger context of clinical and social interventions into child sexual abuse. This study asks: How can the concepts of *dissociation* and *reenactment* as examined through the lenses of Relational Theory and Transformative Justice enhance our understanding and treatment of juvenile sex abusers? And what implications can be gleaned in support of long-term efforts toward ending interpersonal violence?

A preliminary review of the clinical literature shows that although there is extensive multi-disciplinary research on juvenile sexual abusers, there has been little examination of the social and clinical issues surrounding treatment issues with this population from a relational psychodynamic perspective (Wolf & Alpert, 1991). Relational psychodynamic literature on the treatment of child sexual abuse tends to focus primarily on treating survivors, per se (rather than those who are both offenders and survivors, as is overwhelmingly the case with juvenile sex offenders). When offenders are the subject of clinical research, the focus is primarily into the psychology and treatment of adult offenders.[3]

[3] For notable exceptions, please see: Anechiarico, 1990; Burgess, Hazelwood, Rokous, Hartman, & Burgess (1988); Chorn & Parekh, 1997; Fairall, & Gleeson, 2007; Gamache, Diguer, Laverdière, & Rousseau, 2012; Keogh, 2012; & Lothstein, 2001).

A review of the CSA literature also shows that the balance of therapeutic interventions—across mental health disciplines—has weighed heavily in favor of treating child sexual abuse as an individual mental health issue based on the premise that victims and offenders are separate, distinct populations, and largely ignoring the role of bystanders to CSA (Hirschfield-White, 2010). And yet, the complex intrapsychic and interpersonal relationships between victims, offenders, and bystanders must be understood and addressed. Such complex relationships often exist simultaneously within the life of one individual, as is the case for abusers who have themselves been victimized. Perhaps this is nowhere more clear than in the case of juvenile sexual abusers, for whom experiences of sexual traumatization may be particularly recent or ongoing.[4]

Such considerations are critical for the development of optimal interventions into this challenging clinical and social issue, particularly for clinical social workers. Social workers are typically among the first responders to cases of CSA, and work within mental health and child welfare systems that are embedded in complex social relations of power. The criminal legal system is the dominant frame informing clinical practice with people impacted by child sexual abuse, including victims, perpetrators and bystanders. While there exists a diversity of opinion in the clinical literature, the criminal legal system itself, and clinical practice within the system, rely heavily on notions of punishment, shame, and guilt in the treatment of juvenile sex abusers. As social workers, there is a critical need to (re)examine this approach and to consider clinical understandings and treatment possibilities that may be foreclosed by the prevailing paradigm.

In this spirit, this study turns to two theoretical frames—relational psychoanalytic theory and transformative justice—that exist outside the dominant system's approach to child sexual

[4] See, e.g. Burton (2000).

abuse, broadly speaking, and the treatment of juvenile sex abusers specifically. Moreover, these two theoretical lenses offer key insight into understanding trauma, and juvenile sexual abusers, on a micro level (relational theory) and a macro level (transformative justice).

Psychoanalytic theory, broadly speaking, offers critical insight into the role of unconscious mental processes in human behavior and interpersonal relationships (Westen, 1998). Psychoanalytic Relational Theory, in particular, offers unique conceptual tools for understanding and working with unconscious processes and their impact on intrapsychic and interpersonal dynamics. Though its roots date back to the beginning of psychoanalysis, contemporary Relational Theory formally cohered in the 1980s as practitioners from multiple branches within psychoanalysis advanced a theory and practice that fundamentally emphasizes the intersubjective nature of human experience, both in terms of psychological development and therapeutic change. Building on early psychoanalytic thinkers including Janet, Firenczi, Fairbairn and others, Relational Theory has elaborated a view of the mind as inherently multiple, comprised of alternating self-states each with their own self-other representations, associated affects, cognitions and memories. This view of the mind—where consciousness is understood not in terms of horizontally stratified layers but rather as vertically split whole self-states—has evolved in conjunction with renewed psychoanalytic interest in dissociation and trauma. These developments within relational theory offer unique perspectives into the etiology and treatment of traumatogenic dissociative phenomena. For these reasons, Relational Theory is a particularly useful lens through which to examine the complex intrapsychic and interpersonal dimensions of juvenile sexual offending.

Transformative Justice is both a theoretical framework and an emerging social justice movement to build alternative responses to interpersonal violence. There is a growing body of

theory on such alternatives—within the distinct and overlapping frameworks of Transformative Justice, Restorative Justice, and Community Accountability—evolving from these nascent grassroots practices. This emerging theory and practice has primarily focused on the application of Transformative Justice in cases of intimate violence involving adults (where the adult has perpetrated violence against a child, or where an adult has perpetrated violence against another adult (Chen, Dulani, Piepzna-Samarasinha, & Smith, 2011; Creative Interventions, 2012; Kershnar, et al., 2007; Morris, 2000) and little (if any) published literature exists discussing the potential application of Transformative Justice frameworks in treatment with juvenile sexual abusers. I have chosen Transformative Justice to examine the macro, or systemic, aspects in the treatment of juvenile sexual abusers.

This study uses a theoretical approach to examine the etiology and treatment of juvenile sexual offending through the lenses of psychoanalytic relational theory and transformative justice theory. Specifically, I suggest that the concepts of *dissociation* and *reenactment* may illuminate both the micro (individual-psychological) and macro (social-structural) dimensions of juvenile sexual offending. The following chapter provides an in-depth overview of the theoretical orientation and methodology of the study. Chapter Three provides a comprehensive discussion of the phenomenon of juvenile sexual abusers and reviews the clinical and empirical literature on the psychological and social dimensions of this population. Chapters Four and Five expand the introductory discussion of the two theories employed in this study, relational theory and transformative justice, respectively. Finally, Chapter six aims to integrate the perspectives from relational theory and transformative justice to examine the parallel processes of dissociation and reenactment across the individual and sociopolitical dimensions of juvenile sexual offending and to offer suggestions for future research and clinical work with this population.

CHAPTER TWO

CONCEPTUALIZATION AND METHODOLOGY

In this chapter, I provide an overview of the conceptual and theoretical framework for the chapters that follow. Central to this study is the assumption that understanding the intergenerational nature of trauma is a critical component in the treatment of juvenile sexual offenders (JSOs). As will be discussed further in Chapter Three, previous abuse is a significant, though contentious, factor in the etiology of juvenile sexual offending. A second guiding premise of this study is that the individual-psychological and the social-structural dimensions of trauma are both interconnected and, potentially, dialectically related. A question this study proposes, then, is: In what ways can the treatment of JSOs be guided by an examination of the social-structural context within which individual incidences of trauma occur? And, conversely: In what ways can the treatment of individual incidences of abuse inform or contribute to social-structural interventions?

Two concepts—*dissociation* and *reenactment*—connect the individual and the social foci of this study which asks: how can the concepts of *dissociation* and *reenactment,* as examined through the lenses of Relational Theory and Transformative Justice, enhance our understanding and treatment of juvenile sex offenders? More specifically, how do *dissociation* and *reenactment* manifest a) on an individual psychological and behavioral dimension and b) on the social and structural dimension? And, how can an understanding of these interrelationships be integrated to provide optimal clinical and social interventions into the phenomenon of juvenile sex offenders. In this chapter I briefly introduce both theories and present my rationale for choosing each theory to examine this phenomenon.

Dissociation

Dissociation is a complex phenomenon most commonly theorized as a defensive response, usually to traumatic experience. Broadly speaking, dissociation is characterized by a disruption in the integration of a person's conscious psychological functioning (Dell & O'Neil, 2009). This disruption (or intrusion, or alteration) in conscious functioning can affect a person's sense of "body, world, self, mind, agency, intentionality, thinking, believing, knowing, recognizing, remembering, feeling, wanting, speaking, acting, seeing, hearing, smelling, tasting, [and touching]" (Dell & O'Neil, 2009, p. xxi). Although dissociation and amnesia can co-occur and are often linked in clinical and popular conception, Dell and O'Neil (2009) stress that the two are not necessarily concurrent. Dell and O'Neil (2009) note that most dissociative experiences do not involve amnesia, and, in fact, are typically consciously experienced by individuals as they occur. Dissociation is largely a subjective experience that, in most cases, cannot be immediately visible to others (Dell & O'Neil, 2009). Researchers often describe dissociation as existing along a continuum from the ordinary (such as daydreaming) to the more severe (such as dissociative identity disorder) (Gleiser, 2003).

Dissociation is often a critical adaptive response to psychic pain and terror (Gleiser, 2003; Lambert, 2005). Although dissociation can contribute to heightened risk and vulnerability, particularly over time, it is also, often, a survival strategy, particularly in conditions of repeated, severe trauma (Gleiser, 2003). Many dissociation researchers, such as Putnam (1992), have noted that dissociation offers a form of psychological "escape", particularly in the case of childhood trauma: "For a small child, dissociation is the escape when there is no escape" (p. 104). Similarly, Bromberg describes dissociation as an adaptive capacity that "serves to protect against what Reik (1936) called *shock*: the real or perceived threat of being overwhelmingly

incapacitated by aspects of reality that cannot be processed by existing cognitive schemata without doing violence to one's own experience of selfhood and sometimes to sanity itself" (Bromberg, 1998, p. 184). As will be discussed further in Chapter Four, Bromberg, and Reik, speak to the way dissociative processes may be consolidated over time and become an entrenched response to post-traumatic hyperarousal symptomology and the perception of an ever-present threat of repeated trauma or stimuli reminiscent of earlier traumatic experience (van der Kolk, 1989).

Pierre Janet was the first to develop the idea of dissociation as a response to traumatic experience. In his 1889 paper "L'Automatisme Psychologique," Janet presaged contemporary understandings of post-traumatic symptomology, identifying a range of emotional, cognitive and behavioral effects of trauma. Janet saw dissociation as a primary response to trauma and the basis of a host of post-traumatic sequelae (van der Kolk, Brown, & van der Hart, 1989). Janet was also the first to observe the distinctive ways in which trauma alters memory processes, describing a "'phobia of memory'" which causes a dissociated, fragmented relationship to traumatic experience (van der Kolk, et al., 1989, p. 369). For Janet, trauma is characterized by a terrifying helplessness, what van der Kolk, et al. describe as an "inability to take effective action" (1989, p. 368). Because one's mind cannot verbally represent the overwhelming experience of trauma to oneself, the memory cannot be integrated into existing cognitive structures (van der Kolk, et al., p. 368). Traumatic memories are then "split off from conscious awareness and voluntary control" and return later as "pathological impulses (automatisms)" which may manifest as paralyses, amnesias, and behavioral reenactments (van der Kolk, et al., p. 368).

Janet's theories on trauma and dissociation were soon eclipsed by Freud's drive theory, which predominated for years to come (Davies & Frawley, 1994; van der Kolk, et al., 1989). Although Freud's earlier clinical observations aligned closely with Janet's thinking, psychoanalytic interest in the realities of childhood trauma—and, consequently, dissociation—was largely replaced with the emphasis on Oedipal fantasy and the instinctual drives. The child's discomfort with these socially unacceptable instinctive drives, according to Freud's drive theory, led to the creation of defensive structures to protect the conscious mind from such disturbing fantasies. Thus, fantasy largely supplanted actual trauma, and repression largely supplanted dissociation as the primary foci of psychoanalytic theory and technique well into the 1980s (Davies & Frawley, 1994).

Only recently has there been a resurgence of interest in Janet's thinking, across the schools of psychoanalytic thought, and a revival of his theories of trauma and dissociation (Allen, 2001; Bromberg, 1995). Jody Messler Davies and Mary Gail Frawley, in particular, have carried forward the study of trauma and dissociation, adding that it is not only specific traumatic memories themselves which are dissociated, but the entire internalized representation of self and other associated with the trauma, and the associated affect, cognitions and memory, which are internally split-off, or dissociated (Davies & Frawley, 1994). Thus, Davies and Frawley argue, multiple dissociated self-states may coexist in one person's individual personality organization, and have little to no linkages through which to connect these dissociated self-states. Echoing and elaborating upon Janet's observation that dissociated traumatic memories may return in the form of behavioral reenactments, Davies and Frawley (1994) have theorized that such enactments (in the treatment relationship) are the critical means through which such dissociated content may be seen, understood, and, ultimately, integrated.

This conceptualization of dissociation has evolved alongside recent developments in theories of the self within psychoanalytic relational theory. Relational theorists such as Philip Bromberg (1998) have developed a concept of the self which challenges notions of unitary selfhood, proposing, rather, a notion of the psychological self as inherently multiple, representing a multiplicity of "self-states". Within this view of the self, psychological health is partially understood as the degree of access or connectedness among and between "self-states"; dissociation, then, represents a high degree of separateness, or barriers to such access and connectedness. This theory of a multiplicity of self-states builds on, and contrasts with, other psychoanalytic understandings of the self. Object relations theory has been interested, in part, in how early object relations contribute to the formation of a "false self" and seeks in treatment, to create the conditions in which one's "true self" can emerge. Self psychology largely focuses on supporting the development of a more cohesive, integrated self. Relational theory departs from these notions that a unitary self is possible or desired as a treatment goal.

Within this conception of a normative experience of multiple self-states, dissociation can be understood to exist on one end of a continuum of psychological experiences characterized by varying degrees of connectedness between self-states. Dissociation signifies, in part, a high degree of disconnection among self-states, where different self-experiences are inaccessible to one another and, in a sense, cannot coexist (Bromberg, 1998). Unlike ego-defenses, which may selectively alter one's experience, Bromberg (1998) underlines the potentially global impact of dissociation on a person's experience of self. Bromberg describes dissociation as "a defense against trauma, which, unlike defenses against internal conflict, does not simply deny the self access to potentially threatening feelings, thoughts, and memories; it effectively obliterates, at least temporarily, the *existence* of that self to whom the trauma could occur, and it is in that sense

like a 'quasi-death'" (p. 173). This view of dissociation, as will be discussed extensively in chapter four, raises critical implications for clinical treatment, particularly in light of currently predominant models in the treatment of juvenile sexual abusers.

Reenactment

Reenactment, as it is understood in this study, refers to a range of behaviors—individual and relational actions and patterns—which represent some aspect of a repetition of past experience, often unconsciously connected to traumatic memory. As noted above, such behavior has been interpreted as a manifestation of dissociated traumatic memory which has not been integrated into narrative or explicit memory, cannot be accessed through conscious verbal processing and, instead, becomes revealed experientially.

Dating back to Freud and Janet, unconscious behavioral reenactment has been recognized as one among a number of common symptoms of trauma. A conceptually distinctive term for the same phenomenon, Freud struggled to explain the "repetition compulsion" within the context of his drive theory (Mitchell, 1988). Freud's early inquiry into repetition phenomena stemmed from his observation of disruptions in conscious memory connected to overpowering experiences (or, memories and fantasies in his later theories) and the influence such dislocated memories may exert on behavioral and relational patterns repeated across the life course (Gleiser, 2003). Freud observed that such repetition phenomena may manifest in multiple forms: intrapsychically (particularly in the form of traumatic dreams), behaviorally and interpersonally, and in the analytic situation through the patient's transference to the analyst (Gleiser, 2003). The meaning of this tendency to repeat early trauma has been an ongoing, and vexing, question for theorists across the schools of psychology (Gleiser, 2003). While different metapsychological schools

refer to this phenomenon by distinctive terms, several studies have identified abusive reenactment as one among a range of potential symptoms of childhood sexual abuse (Wolf & Alpert, 1991). Specifically, abusive behavior toward others has been found to be a frequently observed symptom among children who themselves have been abused (Wolf & Alpert, 1991).

While there is extensive evidence in the literature that the tendency toward unconscious reenactment of trauma is a common phenomenon in both children and adults, behavioral reenactment appears to be more pronounced among children, who are thought to be more vulnerable than adults to the loss of conscious memory of the trauma and compulsive behavioral repetition (Herman, 1992; van der Kolk, 1989). For children, repetitive play may be one of the primary diagnostic signs of trauma. As Judith Herman has written, obsessive repetition is one of the hallmarks that distinguishes ordinary child's play from post-traumatic play (Herman, 1992).

A host of factors—from the biological to the sociopolitical—may positively or negatively contribute to the risk of reenactment (Allen, 2001). The unconscious nature of dissociative reenactment may, however, be of singular importance in its treatment and resolution. Allen (2001) has found the conscious recognition of one's own abuse history to be the primary factor in preventing the repetition of abuse.

Dissociation and Reenactment in Social Context

Numerous trauma theorists have highlighted the parallels across the individual and social context in public response to trauma (Herman, 1992; Whittier, 2009; Davies & Frawley, 1994). With striking similarity to how trauma is typically handled within families, Herman characterizes the public response to trauma as one of "repression, dissociation, and denial" (Herman, 1992, p.9). And yet, despite this acknowledgement of this significant parallel process, clinical theory

generally does not address the intergenerational, social or systemic aspects of interpersonal trauma. Clinical theory and the profession of social work, moreover, have largely failed to question the larger socio-political context within which individuals—either as victims, offenders or bystanders—are treated in the aftermath of trauma. This study is interested in how an analysis of the relationship between the individual and the social-structural dimensions of trauma and its treatment may contribute to more effective immediate and long-term interventions in the epidemic of childhood sexual abuse.

Central to both relational theory and transformative justice is the relationship between the individual and their larger relational and social context. This study looks at the complex, dialectical relationships between the individual-psychological and the social-structural dimensions as they relate to the phenomenon of juvenile sex offenders. This study focuses on three inter-related aspects of dissociation and reenactment. One aspect is the psychological and behavioral dimension of juvenile sex offenders; how dissociation and reenactment are symptomatic of severe trauma. A second aspect is the social and structural; how dissociation and reenactment operate in the prevailing response to juvenile sexual offenders under the United States legal system. A third aspect of dissociation and reenactment is clinical; how dissociation and reenactment operate within psychotherapeutic treatment.

Relational Theory

In this study, I have chosen to use psychoanalytic relational theory to examine the phenomenon of juvenile sexual abusers on the micro-level. As mentioned above, relational theory is a diverse field within the psychoanalytic tradition, which builds upon multiple branches of psychoanalytic theory including object relations, interpersonal and self-psychology,

intersubjective theory—as well as influences from critical social theory including constructivism and gender theory (Bromberg, 1998; Arnd-Caddigan, 2003). At the heart of relational theory is the contention that people are motivated by relationships, and that the relational context is central to human development and personality structure (Berzoff, 2011; Wachtel, 2008). Fundamentally, relational theory emphasizes the centrality of relationships in both psychological development and therapeutic change.

Specifically, relational theory's conceptualization of dissociation and enactment offers critical insight into understanding and treating trauma. These twin concepts highlight essential differences distinguishing the relational approach to trauma from both cognitive behavioral therapy (CBT), and classical psychoanalytic models. Cognitive behavior therapy—which is the predominant treatment model with sex offender populations—emphasizes the verbally available, conscious aspects of an individual's thoughts, emotions, and behavior (Burton & Smith-Darden, 2001). Classical psychoanalysis understands the pathogenicity of trauma as deriving from intrapsychic conflict that arises in the attempt to repress disturbing endogenous drive content, typically interpreted to be more associated with fantasy rather than actual trauma (Davies & Frawley, 1994). Until recent theoretical work by relational thinkers such as Davies and Frawley (1994), the vast majority of contemporary psychoanalytic writing on the treatment of adult survivors of CSA has been based in drive theory. Drive theory-based understandings of traumatic symptomology emphasize the role of *repression* in which intolerable thoughts, feelings, and memories—here largely understood to be connected to the fantasied meanings associated with early experience and Oedipal conflict—are uncomfortably confined to the unconscious. In contrast, relational theorists, such as Davies and Frawley (1994) emphasize the fundamental impact of trauma on an individual's sense of self, primarily seen in *dissociation*.

In contrast to both the predominant treatment approach, based in CBT, as well as more classically-oriented psychoanalytic or psychodynamic formulations, relational theory emphasizes the relational context in which trauma occurs, and the psychological and interpersonal defenses that are marshaled in response (Davies & Frawley, 1994). Through specific engagement with transference and countertransference dynamics, and attention to reenactments as they emerge in the treatment relationship, relational theory addresses the aspects of traumatic experience that are unavailable to verbal interpretation (Davies & Frawley, 1994). In this way, relational theory specifically recognizes the role of dissociated traumatic experience, and dissociated self-states, in particular, which enter the therapeutic context through clinical engagement with enactments.

Transformative Justice

As a framework that is based in grassroots social movements, Transformative Justice encompasses a range of perspectives and histories. In using this theoretical framework for this study, I am drawing primarily on the work of GenerationFIVE, a non-profit community organization based in Oakland, California. GenerationFIVE is one among a constellation of organizations, collectives and projects building responses to intimate violence based in interrelated, though distinct frameworks including transformative justice, restorative justice and community accountability.

Transformative justice may be described as a macro-level intervention into the collective or systemic dissociative response to intimate violence that characterizes the criminal legal model and its attendant clinical models. Transformative Justice originated in grassroots efforts to develop alternatives to what is seen as the systemic failure of currently existing models to meaningfully respond to, or prevent, child sexual abuse.

One of the key theoretical contributions of Transformative Justice is its analysis of trauma that centralizes the dialectical relationship between interpersonal violence and social relations of power. A framework that originated in grassroots social movement responses to child sexual abuse (CSA), Transformative Justice argues that intimate violence (including rape, domestic violence, and CSA) both reinforces and is reinforced by larger systems of domination and exploitation (such as racism, ableism and sexism) (Kershnar et al., 2007, p. 32). For GenerationFIVE and other TJ organizations, responses to intimate violence, then, must recognize and address the underlying conditions that contribute to (and are furthered by) interpersonal violence.

A central principle of Transformative Justice, then, is that interventions into CSA must attempt to fundamentally shift the power dynamics which allow abuse to occur. This consideration shines a spotlight on the operations of power within prevailing responses to CSA, namely the criminal legal system. Transformative Justice questions the ways in which the criminal legal system replicates the dynamics of abuse and how this fails to offer safety, healing and accountability on an individual level—for survivors, offenders or bystanders—or on a systemic level. Within this frame, questions of individual accountability are shaped by an understanding of the social conditions that contribute to abusive behavior. In the case of JSOs, this includes the legacies of intergenerational abuse. Transformative Justice offers principles for considering the individual and the social in developing interventions that aim to address the root causes of child sexual abuse.

For these reasons, I have chosen Transformative Justice as a framework that will most effectively address the macro-level, or the social-structural aspects of juvenile sexual offending. Transformative Justice emphasizes the dialectical relationship between social and

individual conditions of violence and domination. Transformative Justice is particularly useful in thinking about JSO, where the intergenerational aspect of CSA is particularly central, and where it is necessary to understand how someone can simultaneously be both a victim and offender.

Methodology

This theoretical thesis consists of six chapters. The first chapter provides an introduction to the purpose, the population, and the phenomenon. The second chapter defines important concepts, including the organizing concepts of dissociation and reenactment and an overview of the selected theories. In the third chapter, I provide a detailed description of the phenomenon of juvenile sex offenders, looking at who is criminalized and who is not and what are the trajectories within and outside of the institutions of the legal system for JSOs. In the fourth chapter, I discuss relational theory, including its previous applications to survivors and offenders of child sexual abuse. In the fifth chapter, I discuss transformative justice, and its application to child sexual abuse. Finally, the sixth chapter uses relational theory and transformative justice to discuss the phenomenon of young people who commit sexual abuse. Through the integration of these two perspectives, I offer theoretically grounded suggestions for clinical interventions with this population.

Study Biases and Limitations

As a study of existing literature, this study is limited by the fact that the vast majority of psychoanalytic writing on the topic of child sexual abuse treats the subject of victims of abuse. There is very little written, from a psychoanalytic perspective, about sexual abuse offenders. Within the existing literature about victims of CSA, most empirical studies and clinical case

material is about female clients, and primarily about retrospective work with adult women survivors of CSA. Another limitation is that Transformative Justice is a relatively new movement, with little empirical or theoretical material specifically related to juvenile sex offenders. Given these limitations, I have tried to extrapolate and extend the available research to the understanding of juvenile sex offenders.

This study is also limited by the Eurocentricism of the psychological frameworks considered on the one hand, and the focus on Transformative Justice work happening within North America on the other. Although TJ groups in the US are informed by, and in conversation with, organizers and groups outside the US, this study is limited in scope to Transformative Justice organizing within the US and Canada. Therefore, a possible limitation is that relevant developments in theory and practice outside of the North American context are not included in this study.

Finally, my personal experience working with clients who are survivors of childhood trauma, formerly incarcerated people, and community groups building Transformative Justice responses to child sexual abuse all shape my research and thinking in this study and may contribute to bias. As the rates of CSA discussed in this study demonstrate, most of us have in some way been personally impacted by CSA. In line with the theoretical orientation of this study, it is this author's intention not to ignore or minimize these influences, but to meaningfully and sensitively utilize them with much the same clinical acumen a relational clinician does in the therapeutic setting, ideally in service of clinical practice with all those impacted by juvenile sexual abuse; survivors, offenders and bystanders.

CHAPTER THREE

JUVENILE SEXUAL OFFENDING:

AN OVERVIEW OF THE CLINICAL AND EMPIRICAL LITERATURE

Since the 1980s there has been heightened policy and research attention on the scope of juvenile sexual offending and from 1982 to 1998, there was an increase from 20 to over 800 specialized treatment programs nationally for this population (Becker, 1998). The term "juvenile sexual offender" refers to a heterogeneous population encompassing a diverse range of individual psychosocial characteristics, clinical presentations and treatment needs (Hunter, Gilbertson, Vedros & Morton, 2004; Lowenstein, 2006; Veneziano & Veneziano, 2002). This chapter provides an overview of the clinical and empirical literature on juvenile sexual offenders (JSOs) beginning with a discussion of the terminology concerning JSOs, then providing an overview of child sexual abuse (CSA) and perspectives on JSOs in the context of current research on CSA. I then review the literature specific to juvenile sexual offenders. Finally, I discuss key questions concerning treatment with JSOs.

Language and Terms

The term "juvenile sex offender" refers to a legal minor who has committed sexual offenses which would be considered a crime if they were an adult (Barbaree & Marshall, 2006). The term itself is most directly tied to and perhaps most well-suited to the legal system; 'juvenile' and 'sexual offender' or 'sexual offense' are definitions based in the criminal legal system which distinguishes between children, juveniles and adults for the purposes of individual rights and responsibilities (Barbaree & Marshall, 2006). For clinical purposes, children younger

than 12 who engage in sexual behaviors that would otherwise be considered criminal behaviors are referred to as "children with sexual behavior problems" (Barbaree & Marshall, 2006). For legal purposes, the definition of a juvenile varies widely across jurisdictions in the US. To be convicted of a crime, a person must be considered either a juvenile or an adult by the court in which they are prosecuted. Children as young as 10 can be treated as juveniles in some states, and children as young as 14 may be tried as an adult (Vandiver & Teske, 2006).[5]

Numerous practical, legal and ethical challenges to research with this population have meant that in many ways, the clinical and empirical literature is partly built upon the infrastructure of the legal system, particularly in accessing research participants. The clinical and empirical literature on juvenile (and adult) sex offenders largely follows this legally based typology, perhaps more so than with regard to most other patient populations. While this terminology overlaps, in part, with other frameworks—such as developmental psychology-based constructions of childhood, adolescence, and adulthood—the terms convey distinct connotations. Though not the focus of this study, these discursive differences raise important questions for future research. It is worth noting that the term "juvenile sexual offender" carries a fixed, and potentially intransigent, implication with regard to one very significant aspect of an individual's life and psychological and behavioral history. Banks and Ward (2014) argue against the lifetime labeling of youth with sexually harmful behavior as "sexually deviant", citing research indicating that they are less likely to re-offend than adults. Important alternative terms deserve greater research attention. Some of the literature within the Transformative Justice and community accountability movements utilizes alternative terms such as "person doing harm" (Creative Interventions, 2012) or "person who has abused" (Kershnar, et al., 2007). For this study, I

[5] Policy governing sex offender registries also varies, with individuals as young as 10 (e.g. in Texas) included on some states (Vandiver & Teske, 2006).

primarily use the terms “juvenile sex offender” as well as “juvenile sexual abuser” to maintain consistency with primary source material.

Child Sexual Abuse: An Overview

Despite greater recognition of child sexual abuse as a profound public health concern within the last two decades, there have been few rigorous epidemiological studies, and there is little standardization in methodology across studies, making it difficult to generalize existing research findings on the prevalence of CSA (Pereda, Guilera, Forns, & Gómez-Benito, 2009b). Differences in study findings have been found to reflect the methodological differences across studies rather than actual differences in prevalence rates between study populations (Pereda et al., 2009b). Estimates based on self-report are further limited by the discomfort, shame, and fear surrounding abuse and the specificity of traumatic memory processing in which some experiences may form implicit but not explicit memory (Allen, 2001; Finkelhor, Shattuck, Turner & Hamby, 2014). Due to such difficulties, epidemiological data is widely thought to be an underestimate of overall rates of abuse (Finkelhor, et al., 2014; Vizard, 2013). Such challenges notwithstanding, the most recent data, based on phone surveys of a national sample of adolescents (ages 15, 16 and 17; $n = 2293$), estimate the lifetime experience of sexual abuse and assault to be 26.6 % for girls and 5.1% for boys (Finkelhor, et al., 2014). This figure represents the lifetime experience among 17-year-olds. The authors note that the rate of abuse and assault increased for each additional year of adolescence, with the highest lifetime rate among the 17 year old cohort. For this reason, the authors suggest that future surveys should also include a large sample of 18-year-olds to more accurately and comprehensively estimate lifetime prevalence rates of abuse and assault experienced prior to age 18 (Finkelhor et al., 2014).

Although there continue to be gaps in the epidemiological data, the lines of inquiry have been sharpened since the first national and international studies were carried out. One significant development has been the recognition of differences in the definitions of child sexual abuse, with some researchers and policy-makers referring only to sexual offenses at the hands of an adult and others including offenses committed by adults and juveniles. Finkelhor, et al. (2014) argue that the former definition is misleading and excludes a significant proportion of incidences reported by adolescents in lifetime prevalence surveys. Based on this concern, the authors structured their recent survey to better identify abuse committed by juveniles and by adults. They found that over half of the total estimate of offenses was committed by juveniles, many of them acquaintance peers. The authors emphasize the need for future research to clearly account for and identify the data on sexual abuse committed by both adults and juveniles (Finkelhor et al., 2014).

Estimates of international prevalence rates suggest that there are similar rates of child sexual abuse in all of the countries where epidemiological data exist revealing a pervasive psychological and social problem occurring across socioeconomic and racial categories (Finkelhor, Hotaling, Lewis, & Smith, 1990; Finkelhor, 1994a, 1994b; Pereda et al., 2009b). Again, limited sample size, and methodological differences are found to be the main cause of variation between studies (Pereda et al., 2009a). Socio-cultural differences in openness to talking about abuse may also contribute to differences between sample groups (Pereda et al., 2009a). There is agreement across existing studies and meta-analyses that race and ethnicity are not factors in prevalence rates of CSA (Finkelhor et al., 1990; Putnam, 2003; Pereda et al., 2009b).

Child sexual abuse primarily occurs within the context of relationships of some degree of familiarity; most often, the abuse is perpetrated by someone in a position of some degree of power or authority who exploits some form of trust (Finkelhor et al., 1990). This relational significance, and intrinsic attachment trauma, has been found to compound the psychological harm caused by this form of violence relative to impersonal forms of trauma (Allen, 2001; Radford, et al., 2011).

Whether the rates of CSA have changed over time is a controversial and unresolved question in the literature, in part due to the lack of methodological standardization noted above. Recent studies have found conflicting results, and the question remains inconclusive (Barth, Bermetz, Heim, Trelle & Tonia, 2013; Putnam, 2003).

Gender and CSA Prevalence

Across studies, gender is almost universally found to be a key risk factor for CSA, with significantly higher rates of abuse among females than males. Across the majority of samples, the rate of child sexual abuse among females is estimated to be between 1.5 and 5.5 times higher than that among males (Pereda, et al., 2009a). While actual rates of CSA may be far higher among female children, additional social factors may contribute to the way experiences are understood both by victims, mental health practitioners, and researchers. Rates of disclosure have been found to be quite low generally, although some studies show higher rates of non-disclosure among boys than girls; 42% of boys and 33% of girls reported never having disclosed their experience of abuse to anyone (Finkelhor, et al., 1990).

A rare exception to this trend was reported by Pereda, et al. (2009a), who discussed atypical findings in a study of CSA prevalence rates in South Africa where males reported higher

rates of CSA than females. The overall rates reported in this study were also highest among the 21 countries reviewed in Pereda, et al.'s study. The authors of this South African study (Madu & Peltzer, 2001, cited in Pereda, et al., 2009a) postulated that the higher rates of CSA among males in the sample corresponded to family structure among the sample community (absent males and single parenthood). Pereda and colleagues (2009a) suggested that male participants may have been more open to disclosing childhood sexual experiences than female participants, while reiterating research showing that methodological differences may account for most of the variance between study findings.

Pereda et al. (2009b) discuss the role of social attitudes about gender, masculinity and homosexuality and their possible influence in research design, participant response, and research outcome, particularly with regard to prevalence rates among males. The authors suggest that the relatively lower rates of CSA among males may be, in part, due to the way questions are written from an author bias toward experiences more typical of female victims. Particularly striking is their finding that "[s]ocial attitudes toward sex and stereotypes about the roles of men and women may also prevent men from explaining their experiences, or even mean that they do not regard what happened as sexual abuse" (Pereda et al., 2009b, p. 334). Lambert (2005) similarly discussed the relationship between hegemonic notions of masculinity and the identification of child sexual abuse among male victims. In particular, Lambert (2005) noted that social stigmatization of homosexuality, and the way this may be conflated with abuse in cases of male perpetrators, may compound male victims' reluctance to report sexual victimization. Further research is needed to better understand and develop methodologies that account for these underlying social attitudes and their impact on research.

Symptoms and Impact of CSA

Childhood sexual trauma causes a wide range of both acute and long-term sequelae (Van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005; Davies & Frawley, 1994). As a severe assault on the self and internal and interpersonal relationality, the psychological consequences of CSA can be observed in a number of defensive mechanisms as an attempt to survive. Describing such processes as "massive attempts to protect the psyche and to preserve the self", Terr (1991) observes that childhood sexual trauma is particularly associated with denial, repression, dissociation, identification with the aggressor and aggression turned against the self.

That this abuse occurs during critical developmental years, often in a significant relational context, means that repeated, ongoing experiences of childhood sexual trauma have serious developmental consequences which affect "every aspect of an individual's functioning: cognitive, affective, self-experiential, relational, and behavioral" (Davies and Frawley, 1994, p. 27). Van der Kolk (1989), noting similarly the ways in which early sexual trauma registers at every level of an individual's functioning, adds that such symptoms can also be observed at the level of neuroendrocrinological functioning, which interacts with behavioral, emotional, and physiologic phenomena in the aftermath of trauma.

In addition to the long-term impact on child development, CSA symptomology tend to manifest differently across the developmental stages of childhood and adolescence. In a large meta-analysis of the empirical literature, Kendall-Tackett, Williams, and Finkelhor (1993) identified symptomology most associated with different developmental stages:

> For preschoolers, the most common symptoms were anxiety, nightmares, general PTSD, internalizing, externalizing, and inappropriate sexual behavior. For school-age children, the most common symptoms included fear, neurotic and general mental illness, aggression, nightmares, school problems, hyperactivity, and regressive behavior. For adolescents, the most common behaviors were depression; withdrawn, suicidal, or self-injurious behaviors; somatic complaints; illegal acts; running away; and substance abuse

(p. 167).

Beyond such immediate symptoms, the authors note that virtually all domains of symptomology and pathological behaviors have been associated with a history of sexual abuse.[6] For this reason, there is no singular syndrome or diagnosis associated with CSA (Kendall-Tackett, et al., 1993).

Van der Kolk, et al. (2005) further argue that the effects of prolonged interpersonal trauma, particularly during childhood, can lead to a complex range of symptoms which are not adequately captured in the posttraumatic stress disorder (PTSD) diagnosis.[7] While PTSD symptoms certainly may be present, this diagnosis does not fully represent the range of personal and interpersonal challenges which often foundationally impact individuals with histories of CSA, such as one's "sense of safety, trust, and self-worth; their frequent revictimization; and their loss of a coherent sense of self" (Van der Kolk, et al., 2005, p. 389). Similarly, Terr (1991) draws attention to the often long-term consequences of childhood sexual trauma which are common to survivors irrespective of specific DSM diagnostic categories. The overarching characteristics Terr outlines are: visualized or otherwise repeatedly perceived memories of the traumatic event, repetitive behaviors, trauma-specific fears, and changed attitudes about people, life, and the future.

While there is a wide range of immediate and long-term sequelae, sexualized behavior and PTSD symptoms are the most frequently observed symptoms of CSA (Kendall-Tackett, et

[6] While not all victimized children have psychiatric sequelae, research indicates that children who appear asymptomatic upon initial evaluation may in fact pose a higher risk for later deterioration (Putnam, 2003).
[7] The Diagnostic Statistical Manual-IV-TR (the volume in use at the time of this study) defined PTSD according to the following (abbreviated) diagnostic criteria: A) The person has been exposed to a traumatic event; B) The traumatic event is persistently re-experienced; C) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma); D) Persistent symptoms of increased arousal (not present before the trauma); E) Duration of the disturbance is more than 1 month; F) The disturbance causes clinically significant distress or impairment in important areas of functioning (American Psychiatric Association, 2000).

al., 1993). Earlier age of onset of sexual abuse is associated with a greater incidence of hypersexual, exposing, and victimizing sexual behaviors (Van der Kolk, et al., 2005; Vizard, 2013). Kendall-Tackett and colleagues (1993) note that age, a range of abuse-specific factors, and the quality of familial and community support following disclosure, can contribute to the nature and severity of symptoms.

Vizard (2013) reports that inappropriate sexual knowledge, sexual interest and sexual acting out appear to be the strongest indicators of past abuse. Several studies report that sexual preoccupation and the repetitive reenactment of one's own victimization history are common symptoms of sexual trauma (Burton, 2003; Veneziano, Veneziano & LeGrande, 2000; Finkelhor & Browne, 1985). Describing such symptoms as "sexual compulsivity", Hunter (2010) suggests that this may represent a manifestation of a "'re-experiencing phenomena' (i.e. intrusive sexual cognitions and affects)" associated with PTSD (p. 369).

Van der Kolk (1989), who has reported that reenactment and repetition phenomena are a significant and widespread response to trauma, describes such symptomology as generally unconscious processes, which may have a defensive and even self-medicating effect. Van der Kolk writes that reenactment and repetition behaviors can engage powerful physiological systems such as the stress-induced analgesia effect of re-exposure to stressors following traumatic experiences. Van der Kolk describes the physiological numbing effect of re-exposure experiences—which activate endogenous opioids—as equivalent to that of morphine (Van der Kolk, 1989). As is often the case with defensive patterns more generally, the effects of such reenactment phenomena are paradoxical: "although [compulsive repetition of the trauma] may provide a temporary sense of mastery or even pleasure, [it] ultimately perpetuates a subjective sense of being bad and out of control" (van der Kolk, 1989). As will be explored further below

and in Chapter Four, the defensive or numbing effects of traumatic repetition may be an important area of further inquiry in the treatment of juvenile sexual abusers.

Though beyond the scope of this study, it is worth mentioning that in addition to the significant variation in symptomology and responses to trauma, victims of sexual abuse also demonstrate significant variation in resiliency (Kendall-Tackett, Williams & Finkelhor, 1993).

The Non-Inevitability of Abuse Repetition

Before focusing specifically on the research concerning juvenile sexual offenders, it is important to clarify the ways in which the relationship between the symptoms of childhood sexual trauma and juvenile sexual offending are understood in this study. As discussed above, behavioral symptoms are common among children who have suffered sexual trauma, including inappropriate sexual behavior, and behavioral reenactment of their own abuse. If, as this research may suggest, inappropriate, harmful and abusive sexual behaviors are possible symptomatic responses to sexual trauma, clinical and policy-oriented practice can do more to better integrate this understanding in working with young people who have perpetrated abuse. To explore the ways in which a small percentage of those who have been abused may perpetuate similar abuse, however, is not to say that this repetition is inevitable. In fact, the fear of resembling or behaving similarly to past abusers can often be a source of great distress among trauma survivors (Allen, 2001) and to misconstrue the cycle of abuse theory can add to the shame and stigma survivors already endure (Cannon, 2001).

Critically, there is widespread agreement across the literature that although there are strong and highly complex correlations between abuse history and subsequent abusive behavior, this does not indicate a deterministic causality (Allen, 2001; Bailey, 2001; Garland and Dougher,

1990). The vast majority of victims of sexual abuse do not go on to perpetrate sexual abuse (Leifer & Smith, 1990). Putnam (2003) notes that studies on the intergenerational transmission of abuse have tended to include sexual abuse together with other forms of child maltreatment; as a result, little is known about the intergenerational transmission of CSA specifically. For sexual offenders who have themselves been victimized, a host of intervening factors shape how the abuse is experienced, how the abuse impacts the child's development, and subsequent offense behavior. Garland and Dougher (1990) identify a number of such intervening variables including the age of sexual victimization, the severity of the victimization, the use of force, the gender of the perpetrator, the duration and frequency of the abuse, and the number of perpetrators. Similarly, Burton (2000) suggests a proportional relationship between high levels of ongoing, prolonged trauma (including sexual abuse, emotional abuse and other traumas) and sexual offending behavior. Putnam (2003) discussed preliminary research from two studies which found that there may be differential gender effects related to the cross-generational replication of abuse, with fathers found to be more prone to abusive behavior, and mothers more prone to fail to intervene to stop abuse. This raises important questions into the relationships between gender socialization and trauma symptomology across the life course. These initial findings also suggest that further research is needed into the role of trauma histories in bystander responses, and greater understanding of the roles and relationships among bystanders and offenders.

Co-factors of childhood sexual abuse also complicate narrow interpretations of the cycle of abuse hypothesis, and point to the difficulty in using this hypothesis to attempt to predict the likelihood of abuse in individual cases (Cannon, 2001; Putnam, 2003). In a study comparing child sexual abusers with histories of sexual abuse with child sexual abusers who had not been

sexually abused, Seghorn, Prentky, and Boucher (1987) found that those who had been sexually abused were more likely to have also experienced the following co-factors in their childhood: fathers with criminal and/or substance use history, parents with psychiatric problems, sexual deviance within the family and a high incidence of childhood neglect. Given this range of associated factors, child sexual abuse itself cannot be isolated as a causal factor in subsequent sexual offending (Cannon, 2001).

Further research is needed to examine the influence of the relational context of the abuse. Wyre (2000) argues that the relational characteristics of the abuse, including the nature of controlling behavior, correspond to the likelihood of the victim going on to victimize others more than the nature of the abuse itself (cited in Bailey, 2001). Greater understanding of such risk factors, as well as protective factors can improve treatment for individuals who have been abused and guide broader intervention into and prevention of CSA. Indeed, Breitbach and Freeman (2004) observe that the literature on juvenile sexual offending tends to emphasize risk factors to the exclusion of factors that foster resilience. They further assert that an appreciation for individual's strengths and positive characteristics can improve treatment both in terms of preventing recidivism and promoting resilience.

Juvenile Sexual Offenders: Scope of the Problem

Researchers are increasingly recognizing the scope of juvenile sexual offending as a significant proportion of total cases of child sexual abuse. It is estimated that 20% of all sexual assaults and between 30 and 50% of all child sexual abuse in the United States is committed by adolescents, the majority of whom are adolescent males (Barbaree & Marshall, 2006; Hunter, Figueredo, Malamuth, & Becker, 2003; Lowenstein, 2006; Veneziano, et al., 2000). Vizard

(2013) reports a higher estimate from a recent study in the UK which found that 57.5% of contact sexual abuse (of children up to age 17) was perpetrated by children and young people, 34.1% by adults, and 8.4% by both adults and children or young people. These findings indicate that child sexual abuse perpetrated by children and juveniles may be more prevalent than abuse perpetrated by adults (Vizard, 2013). Veneziano, et al. (2000) note that these figures are likely to underestimate the scope of the problem, as many incidents are never reported or prosecuted. As is the case with CSA perpetrated by adults, juvenile sexual offenders typically victimize someone who is a family member (including siblings and extended family members), or peer (Keelan, & Fremouw, 2013; Vandiver & Teske, 2006; Veneziano, et al., 2000; Vizard, 2013).

Empirical studies indicate that nearly half of adult offenders first sexually offended during adolescence, and that the frequency and severity of victimization increased over time (Veneziano, et al., 2000).[8] This does not, however, imply that the inverse is the case for adolescents with sexually abusive behaviors. According to Caldwell (2007), the majority of JSOs do not sexually offend as adults, and are more likely to commit non-sexual offenses than sexual offenses. Caldwell (2007) suggests that current research shows that JSOs do not "specialize" in sexual offending compared to adolescents who have not been involved in the legal system. Numerous ethical and methodological challenges complicate the research on recidivism rates among adolescent sexual abusers. In a recent review of the literature, Keelan and Fremouw (2013) report that overall sexual recidivism rates across the studies reviewed ranged from 0 to 20%. Veneziano and Veneziano (2002) report initial research indicating that young people are more responsive to treatment than adult offenders.

[8] The authors do not specify whether this prognosis of sexual offending over the life course for adult offenders refers to offenders who have or have not received treatment.

Burton (2000) studied whether adolescent sexual offenders may exhibit sexual behavior problems as children. Based on self-reported survey responses of incarcerated juvenile sex offenders, Burton found that over 46% of the youth began their sexually aggressive behavior prior to age 12. The likelihood that young sexual abusers will reoffend—or are more likely to commit sexual offenses than those without a known history of sexual offending—however, is not established. Becker (1998) raises caution in the question concerning the treatment of young sexual abusers noting that there is not yet longitudinal data to support the notion that if a young person commits one sexual offense they will develop a pattern of sexual-offending. Recidivism and treatment efficacy will be discussed further later in this chapter.

Etiology

There is little consensus in the literature on the etiologies and developmental course of juvenile sexual offending (Becker, 1998). While a variety of overlapping and divergent theoretical perspectives—including attachment theory, cognitive-affective theory, ecological theory, intergenerational transmission of abuse or cycle of violence theory, psychodynamic theory, and social learning theory—inform the literature (Banks & Ward, 2014; Barbaree, Blanchard, & Langton, 2003, Bischof & Rosen, 1998; Burton, 2003; Lyn & Burton, 2004; Miller, 2010), there has been a lack of longitudinal studies, theoretically driven research and specific discussion of the etiological mechanisms which lead to sexual offending behavior (Becker, 1998; Miller, 2010). Given the preponderance of clinical and empirical data demonstrating high rates of sexual trauma (and other emotional and physical traumas) among sexual abusers, the "abused-abuser hypothesis" has been a central focus of much research, with

significant differences, however, in the treatment implications as interpreted across theoretical perspectives (Miller, 2010).

Social learning theory is one of the leading, and more empirically studied, theories on the etiology of juvenile sexual abusers (Burton, 2000). Burton (2003) summarizes the tenets of social learning theory as applied to juvenile sexual offending as an iterative process by which a sexually abusive youth initially acts out based on internalized social modeling, anticipated rewards (that they perceive their offenders to attain), environmental reinforcement of minor rule breaking, and cognitive distortions regarding sexual behavior and potential victims. The youth may then continue to sexually abuse due to an ongoing attempt to resolve sexual trauma, conditioning related to sexuality, as a response to intrapsychic conflict, and/or possible addiction (Burton, 2003).

Banks and Ward (2014), discuss similar findings in a composite case study of the treatment of a 14-year-old boy with sexually harmful behavior within an attachment-based framework. Congruent with Burton (2000; 2003), Banks and Ward (2014) explore the ways in which this client had developed coercive behavioral strategies as an attempt to manage high levels of stress. Banks and Ward (2014) cite research looking at the neurological, emotional, and developmental impacts of trauma and neglect, findings which indicate that coercive, controlling behaviors toward others may be particularly common among individuals with a disorganized attachment style as an attempt to self-regulate. The authors discuss the use of narrative in therapy to help integrate neural networks, and help create new tools for self-regulation.

Derived from social learning theory, several studies have examined the victim-victimization hypothesis, studying whether and how the victimization history of sexually abused adolescents relates to their sexually abusive behavior. Veneziano, et al. (2000) found strong

correlations between the characteristics of adolescent male sexual offenders' abuse history and their abusive behavior. Veneziano et al. (2000) found significant correlation between the characteristics of the adolescents' sexually offending—age, gender, relationship to the offender, and specific sexual behavior—and that of their own sexual victimization. For example, the authors found that subjects who were victimized when they were younger than age 5 were twice as likely to abuse someone younger than age 5. The authors conclude that this study supports the conception that for adolescent sexual offenders, their sexual offending behaviors represent a reenactment of their own experience of sexual abuse, or a reactive conditioned and/or learned behavior.

Burton (2003) tested this "victim-victimizer" hypothesis further in a study examining the cases of male youth (*n = 179)* in a residential treatment program who had self-reported committing sexual offenses and to being sexually victimized. Burton compared characteristics of the youths' sexual victimization and the same characteristics of the youths' abusive behavior. Burton found striking similarities between the victimization experiences the youth themselves had suffered and the offenses they perpetrated. Youth were likely to abuse someone similar in terms of age, gender and level of relatedness (family v. stranger) to the person(s) who had abused them. Further, the modus operandi was highly correlated between the youths' own victimization experience and that of their offense behavior. Similar to Burton (2003) and Veneziano, et al. (2000), Roe-Sepowitz and Krysik (2008), in a study of female sexual offenders with histories of sexual abuse themselves, found that early onset of sexual abuse was associated with greater force or coercion in the sexual abusive behavior they committed.

Notably, Burton reports that despite agreement in the literature that "youths' sexually abusive behavior tends to mirror what was done to them" (DiCenso, 1992, cited in Burton, 2003,

p. 288), among youth who have perpetrated sexual abuse, "it is clear that the youth do not do all of what is done to them; on an overall basis, they do not commit acts as severe as the ones committed against them" (Burton, 2003, p. 291). Burton notes, however, the difficulty in comparing the relative severity of different abuse experiences.

There is very little psychodynamic or psychoanalytic scholarship concerning juvenile sexual offenders. As noted in Chapter 1, psychoanalytic literature on child sexual abuse has largely focused on treating survivors (in childhood and adulthood), with a small number of articles concerning adult sexual offenders (Wolf & Alpert, 1991). In one of the few psychoanalytic articles specifically on JSOs, Gamache, Diguer, Laverdière, and Rousseau (2012) develop a typology identifying subtypes of adolescent sex offenders based in object relations theory and Kernberg's model of personality organizations. Given the widely recognized heterogeneity among JSOs, Gamache, et al. (2012) outline treatment implications for the offender subtypes identified, emphasizing the need to adapt interventions according to differing subgroup and individual treatment needs. One of the most comprehensive psychodynamically-informed studies, is Rich's book (2006) examining the etiology and treatment of JSOs from an attachment theory framework.

Fonagy, Moran and Target (1993) have explored aggression more broadly. Challenging the polarizing tendencies within psychoanalytic theories on the origins of aggression, Fonagy and co-authors develop a theory of aggression's defensive role in both normal and abnormal development. They argue that aggression serves a defensive role in the protection of self-representation and identity but may develop into pathological aggression out of a developmental context in which a child is unable to develop an appreciation of the mental states in the other. When a primary caregiver is hostile or unpredictable, it will be unsafe or painful for the child to

recognize the caregiver's mental states and the child may be unable to develop reflective capacity about themself or the other. Defenses of aggression and avoidance may become organizing personality structures such that aggressiveness and destructiveness may take the place of emotional relatedness. Fonagy, et al. (1993) present a case study illustrating how psychoanalytic treatment focused primarily on the analytic relationship (rather than intrapsychic conflict) can help foster the patient's development of a reflective self.

Offender Characteristics

A wide range of variation exists across studies examining the prevalence of sexual abuse histories among JSOs (Keelan & Fremouw, 2013). This variability would appear to be, in part, a result of the same methodological inconsistencies across prevalence studies of CSA in the general population discussed above. For example, one study, which surveyed a sample of male JSOs (*n = 182)* in residential treatment programs, found that 75% reported a history of sexual victimization (Hunter, et al., 2003). A second study, which utilized Child Protective Services records, found that 39% of the sample had a documented history of sexual victimization (Richardson, Kelly, Bhate, & Graham, 1997). Similarly, Veneziano, Veneziano and LeGrand (2000), also studying male JSOs in residential treatment (*n = 74*), found corroborating evidence that 92% of the cases had a prior history of having been sexual abused. A study based solely on secondary data (from joint police and social service department investigations) on JSOs in residential programs in the UK found that 39% of the sample had a documented history of sexual abuse prior to the onset of their abusive behavior (Richardson, et al., 1997). The strength of these findings is limited by the fact that, like other studies of JSOs, both samples are limited to individuals who have been adjudicated for their offenses. Further, the differences in data

collection methods (self-reporting vs. corroborated documentation) contribute to the differences in the findings.

Despite such methodological differences and challenges in estimating the prevalence of sexual abuse history, an aggregate estimate based on multiple prevalence studies, finds a history of sexual victimization among 50 to 65% of sexually aggressive adolescents (Burton, 2000). According to conservative estimates, it appears that rates of sexual victimization among male adolescent sexual offenders are three to four times that of the general male adolescent population (Burton, 2003). Rates of sexual victimization among younger children (under the age of 12) with sexual behavior problems are significantly higher, with estimates ranging from 65 to 100% (Burton, 2000).

For juvenile sexual offenders with no evident history of sexual victimization, Woods (1997) reports findings of a high degree of other forms of physical and emotional abuse and neglect. High rates of histories of physical, sexual and emotional abuse or neglect have been reported across the literature on male and female sexual offenders (Fehrenbach & Monastersky, 1988; Hunter, 2010; Roe-Sepowitz, & Krysik, 2008). Few studies have examined exposure to violence and abuse among youth who had committed sexual offenses. In one of the few available studies including exposure as well as direct victimization among juvenile sexual offenders reveals severe histories of complex trauma among the participants. In a survey of JSOs (*n = 182)* in residential treatment programs, Hunter, et al. (2003) found that more than 75% of the sample had witnessed some form of sexual or physical violence toward females; 53.8% had witnessed a male relative beat a female; 48.6 % witnessed a male relative threaten another male with a weapon; 75% of the sample reported childhood sexual victimization, of whom

44.2% had been sexually abused by both a male and a female perpetrator; 63.3% of the overall sample reported physical abuse by a father or stepfather (Hunter, et al., 2003).

Research on adolescent sexual abusers has tended to study males and females separately and there is far more research on male sexual abusers than females. Consequently, there is a limited base of clinically and empirically supported knowledge on female sexual abusers (Lowenstein, 2006; Kubik, Hecker, & Righthand, 2002); Becker & Hunter, 1997). While there is a limited number of studies, findings based on convicted juvenile sex offenders demonstrate that an estimated 5-10% of all JSOs are female (Roe-Sepowitz & Krysik, 2008). These findings raise yet under-examined questions about what may account for these gender differences. More research is needed to explore whether male JSO cases are more likely to be brought to the juvenile courts. Further research is also needed in exploring possible differences in the etiology of sexual abusive behavior among males and females.

Similar to the estimates of CSA among the general population, research indicates higher rates of sexual victimization histories among female sexual offenders in comparison to their male counterparts. In a study examining characteristics of female juvenile sexual offenders placed in community-based or residential treatment, Mathews, Hunter and Vuz, (1997) found a history of childhood sexual victimization among 75 to 90% of study participants. The authors characterize the developmental histories among female JSOs to reflect "even more extensive and severe maltreatment", and earlier age of onset of abuse, than that among male JSOs in the same study. Kubik, Hecker, and Righthand (2002) report similar findings. Kubik, et al. (2002) compared adolescent females with sexual offense histories with age-matched adolescent males with sexual offense histories and found significant similarities between the two offender groups' psychosocial histories and offense behaviors. Notable differences, however, were observed in

the offender groups' abuse histories, with the female sample reporting more severe and pervasive abuse histories compared to the male sample. As discussed above, such estimates are limited by the potential methodological biases that make it difficult to accurately collect data on male abuse histories.

Treatment

Therapeutic treatment.

Cognitive behavioral therapy-based treatment is the predominant model in most programs for juvenile sexual offenders in the US (Burton, 2003; Burton & Smith-Darden, 2001). Treatment models for juvenile sexual offenders is largely based on research and interventions developed for adult sexual offenders (Letourneau & Miner, 2005) and has followed shifts in adult offender treatment away from psychoanalytic psychotherapy and toward an emphasis on CBT (including cognitive restructuring, aversive conditioning, social skills training and psychoeducation) combined with relapse prevention addiction models (Anechiarico, 1990). In a large study of residential and community-based treatment programs (*n = 217 programs*), Burton and Smith-Darden (2001) found that 79 % utilized a cognitive behavioral/addiction-relapse prevention approach and none of the programs utilized a psychodynamic model.

There is a dearth of research on the comparative effectiveness of therapeutic models in the treatment of JSOs. Nearly all effectiveness studies in the empirical literature on JSO treatment are based on CBT programs (Burton, 2003). Hunter, et al. (2004) note the need for expanded research, and call into question basic assumptions at the foundation of most JSO treatment programs in the U.S. Particularly of interest for this study, they suggest that evidence is needed to evaluate key premises behind prevailing treatment models including the assumptions

that "treatment should be primarily focused on the sexual offending behavior and its presumed causes; and that sexual offending is largely a function of deviant sexual interests and social skill and cognitive processing errors that can be effectively addressed by clinicians in controlled, therapeutic environments (e.g., the therapist's office)" (Hunter et al., 2004, p. 178.). Such questions point to the need for a reexamination of currently predominant treatment models and for further research into ecological models of treatment with this population.

In a unique study on treatment efficacy and recidivism rates, Worling and Curwen (2000) compared treatment outcome data for adolescent sexual offenders in two different treatment groups through a 6-year follow-up interval. The study, which took place in Toronto, Canada, compared 1) a community-based treatment program which typically includes concurrent group, family, and individual therapy, including cognitive-behavioral and relapse prevention strategies; and 2) a comparison group which received treatment elsewhere in the community, and/or dropped out of treatment. Worling and Curwen (2000) found that this comprehensive treatment approach reduced the risk of subsequent sexual offending (as well as nonsexual offending) significantly; "Recidivism rates for sexual, violent nonsexual, and nonviolent offenses for treated adolescents were 5.17%, 18.9%, and 20.7%, respectively. The Comparison group had significantly higher rates of sexual (17.8%), violent nonsexual (32.2%), and nonviolent (50%) recidivism" (Worling & Curwen, 2000, p. 965). The authors note that the success of the specialized treatment program centered on the integration of a strong family-relationship component with individual offense-specific interventions. These findings are consistent with reports on the efficacy of multisystemic treatment of adolescent sexual abusers.

Multisystemic therapy (MST) is one of the only treatment models to have been rigorously studied in the treatment of JSOs, utilizing a pretest-posttest control group design and randomized

assignment. MST is an ecological treatment model that integrates individualized interventions—clinical techniques including behavioral, CBT, and structural family therapy—into a youth's larger social context (Borduin, Schaeffer, & Heiblum, 2009, pp. 27-28). Comparing MST with usual community services (UCS), and an average 8.9-year follow-up period, Borduin, and co-authors found significant improvement in recidivism rates for both sexual and non-sexual offenses: MST participants sexual recidivism rates were 8% (compared to 46% in the UCS group) and 29% for nonsexual offenses (compared to 58% respectively). Noting the difficulty in identifying specific mechanisms of change, the authors attribute the relative efficacy of MST to the recognition and integration of the multi-determined nature of sexually abusive behaviors in this treatment (Borduin, et al., 2009).

Beyond the treatment modality itself, there appears to be little research assessing for the impact of the institutional context (e.g. community-based versus correctional facilities settings) on treatment efficacy. Clinically-relevant institutional factors merit further investigation, such as who is administering treatment and whether they have what would be considered for clinicians to be a "dual relationship" with the young people they are treating. For example, in the juvenile sexual offender unit of the Cook County (Illinois) juvenile probation department, sex offender treatment groups are led by probation officers who have completed a certification course for this specific treatment method (Letourneau, Hengeller, Borduin, Schewe, McCart, Chapman, & Saldana, 2009). At the time of one treatment comparison study, which included this unit, there were seven specially trained "treatment probation officers", three of whom held clinical licenses (Letourneau, et al., 2009). The study did not specify whether the officers were also responsible for disciplinary supervision of the youth in their treatment groups.

Treatment and the Legal System.

Juvenile adjudication trends over the last two decades have paralleled the exponential rise in incarceration rates in the US generally.[9] Throughout the 1990s, stricter sentencing laws (across the juvenile and criminal court systems) swept the US states, leading to the unprecedented rise in juvenile incarceration rates (Billitteri, 2010).[10] As juvenile adjudication rates have risen, juvenile courts have increasingly relied upon harsher interventions, favoring "boot camps" and incarceration over community-based, programs (Letourneau & Miner, 2005). For juveniles adjudicated for all offenses, court-ordered residential placement of youth in the US grew by 56 percent from 1988 to 1997 (Hunter, et al., 2004). For adolescent sex offenders, specifically, the trend has also been toward court-ordered residential treatment with a 16 percent decrease, nationally, in community-based programming relative to residential placement (Hunter, et al., 2004).[11] Hunter, et al. suggest that such patterns are both reflective of national trends toward harsher legal sanctions for juveniles, and a result of a shortage of community-based programming nationally.

As juvenile adjudication rates have risen dramatically, so too have the number of adolescents and younger children now being tried as adults and excluded from the juvenile justice system (Letourneau & Miner, 2005). Within adult correctional facilities, juveniles are less likely to have access to therapeutic treatment and are at high risk for adverse experiences

[9] For an overview and analysis of the rise of mass incarceration in the latter part of the 20th century, see Davis (2003). For additional analysis and research on the subject, see: Alexander (2010), Gilmore (2007), Parenti (1999), and Sudbury (2005).

[10] According to a report from the Annie E. Casey Foundation, the one-day count of state prisoners under 18 rose 135 percent from 1985 to 1997 and "the average daily population in juvenile detention facilities more than doubled in that time span, to 28,000" (Billitteri, 2010, p.205).

[11] A seemingly euphemistic term, "residential treatment" is an overarching name within the categories of secure detention and secure confinement for juveniles and can refer to a range of programs including detention, corrections, camp, community-based and residential treatment facilities (Office of Juvenile Justice and Delinquency Prevention, n.d.).

and iatrogenic effects including increased recidivism (Letourneau & Miner, 2005).

Though not found in the clinical literature on JSOs, studies outside of the mental health field have reported alarming rates of violence within juvenile correctional facilities. According to a recent report from the US Department of Justice (cited in Billitteri, 2010), "an estimated 12 percent of adjudicated youth in state-operated and large locally or privately operated juvenile facilities reported being sexually victimized by another youth or staff member in the past year or since their admission if less than 12 months" (p. 197). Thirteen of the juvenile facilities surveyed *(n=195 facilities)* reported more than a 20 percent sexual-victimization rate, of which six of the facilities had rates of 30 percent or above (Billitteri, 2010). The study also reported high rates of physical violence from staff resulting in serious injuries.

Though this researcher did not locate national data on adjudication patterns for JSOs, smaller studies provide such data for specific samples. Vandiver and Teske (2006), for example, in a study of adjudicated JSOs in the state of Texas, reported that the average sentence length for male JSOs *(n = 122)*, including probation and incarceration, was 5.5 years.[12]

Few studies have directly examined adjudication patterns in relation to race, socioeconomic status, gender or other characteristics of individuals facing involvement in the juvenile justice system for sexual offenses. The first (and possibly the only) study to directly examine racial differences among adolescent sexual abusers,[13] Burton and Meezan (2007) found indications of institutional racism in the adjudication patterns for these youth. Burton and Meezan (2007) found that among the group of adjudicated adolescent sexual abusers, the

[12] "Ninety-four (77%) of the male offenders received a sentence of probation, and 27 (22%) received a sentence requiring residential treatment. Sentencing information was missing for 1 offender (1%). Sixty-one (50%) received a sentence of less than 5 years, 27 (22%) received a sentence between 5 and 9 years, and 33 (27%) received a sentence of more than 10 years (missing = 1, 1%). The average sentence length, including probation and incarceration, was 5.5 years (*SD* = 4.5)" (Vandiver & Teske, 2006).

[13] ASA refers to both adjudicated and non-adjudicated adolescents.

Caucasian youths in the sample reportedly committed more serious offenses compared to the African American youths in the sample. Burton and Meezan (2007) suggest that "rather than juveniles who commit similar offenses being sentenced to the same facility type, African American youths' placement in…secure residential facilities might be explained by institutional racism. These African American youths, who committed less serious offenses, were placed in the same facilities as Caucasian youths who committed more serious offenses" (p.116). Though systematic studies on a larger scale have not yet been carried out, these findings are consistent with secondary data this researcher extracted from studies in which racial differences were not the explicit focus.

Racial demographic data gleaned secondarily suggest that young people of color are disproportionately represented among incarcerated juvenile sexual offenders. In a study of incarcerated sexual offenders in Michigan (*n=243*), Burton (2000) reported that 40% of the sample was Euro American, 40% African American, 6% Hispanic, 9% Native American, and 5% other ethnicities. While the study utilized a nonrandom sample, Burton notes that the sample represents approximately 75% of all incarcerated adolescent sexual offenders in Michigan. In contrast, the U.S. census for Michigan in 2000 (the year the study was published) reports the following demographics for the state's population (of all ages): white 78.6%, African American 14.1%, Hispanic or Latino 3.3%, American Indian and Alaska Native, 0.5%, and 0.1 % some other race (U.S. Census Bureau, 2000). Though an informal analysis of data from one state, this sample demonstrates that the incarceration rate of JSOs in Michigan is consistent with racially disproportionate incarceration patterns nationally (Alexander, 2010; Nellis, 2012).

Similarly, one of the largest studies reporting adjudication data for JSOs included striking data on race and differential criminalization rates. Based on data from sex registries in the state

of Wisconsin, Caldwell (2007) compared recidivism patterns of a cohort of JSOs (*n=249)* and non-sexual juvenile offenders (*n=1,780)* following their release from secured custody. In this sample of formerly incarcerated juveniles, 47.2% of the participants were African-American, 48.2% were white, 1.7% were Native American, and 1.0% were Asian (Caldwell, 2007). Though the study does not delineate this demographic profile separately for the JSO cohort and the non-sexual juvenile offenders, the author notes that there were no significant differences in demographic makeup between the sex offender and other groups. Again, this contrasts sharply with the corresponding US Census data,[14] indicating that African American, Native American, and Asian young people are disproportionately targeted by the legal system. Vandiver and Teske (2006) reported similar data in a study looking at JSO judicial processing characteristics in Texas.

One study of female JSOs in the state of Florida (Roe-Sepowitz & Krysik, 2008), which included racial demographics in a brief discussion of the study's sample selection process, reported finding no significant differences regarding race (or age, or region of the state) in the adjudication process. Further research to systematically examine racial and socioeconomic factors in the prosecution of JSO cases. Similar to the studies noted above, the sample in this Florida study appears to over-represent African American juveniles relative to the statewide population.[15] This was not discussed by the study's authors.

Without studies directly examining the relationship between race, ethnicity, other sociocultural factors and adjudication rates among juvenile sexual offenders, larger conclusions cannot be drawn from these limited findings. However, it is clear from incarceration rates more

[14] The 2007 U.S. Census provides the following demographic estimates for the state of Wisconsin: White, 88.5%; Black or African American, 6.1%; Hispanic or Latino (of any race), 4.8%; American Indian and Alaska Native, 0.8%; and Asian, 2.0% (U.S. Census Bureau, 2007).
[15] Sample participants were 61% white, 33.1% African American, and 5.9% other (Roe-Sepowitz & Krysik, 2008).

broadly, that people of color generally, and African Americans in particular, are disproportionately targeted by the US criminal legal system (Alexander, 2010). Research on overall juvenile incarceration rates shows similar results. A recent report from the Sentencing Project found that African American youth face disproportionately high rates of incarceration in the juvenile system and are also much more likely to be incarcerated within adult prisons (Nellis, 2012). Further research is needed to study cases of adolescent sexual abusers in which the juvenile system is never involved, including how factors including race, socioeconomics, age and gender influence how incidences are handled within and outside of the juvenile system.

Treatment Implications

The current literature on juvenile sexual offending offers important directions for future research as well as significant implications for treatment of JSOs clinically and systemically. First, in terms of clinical treatment, the finding that JSOs are a heterogeneous population with varied and multidetermined clinical needs aligns with efficacy findings in support of multisystemic treatment that integrates individualized clinical interventions into the youth's larger ecological context. Secondly, though the etiological research is far from conclusive, the findings indicating that JSOs abusive behavior is reflective of their own victimization reinforces the need to further develop the small body of psychodynamic literature on traumatic reenactment and to begin to apply this theoretical work toward clinical practice and empirical research.

The implications for JSO treatment within larger social systems are particularly troubling. The under-examined prevalence of physical and sexual violence within juvenile correctional facilities raises great concern. The preliminary data on the disproportionate criminalization of African American and other communities of color among adjudicated JSOs also raises critical concerns. Further, estimates suggest that the criminalization of some individuals who have

committed sexual offenses represent a small fraction of total incidences of adolescent sexual violence. According to one estimate, "the ratio of self-reported to adjudicated sexual crimes by juveniles is approximately 25:1" (Elliott, 1995; cited in Borduin, et al, 2009). Similarly, based in a longitudinal study of sexually violent behavior among college-enrolled men, Abbey (2005) estimates the prevalence of sexual assault committed by adolescent boys to be one in four (Caldwell, 2007). Caldwell (2007) notes that such findings point to the limited effectiveness of law enforcement interventions in reducing sexual violence. Further, the reports of physical and sexual violence within juvenile correctional institutions suggests that the courts themselves are culpable in the continued replication of child sexual abuse. As we will consider in the following chapters, such findings indicate the great need for alternative individual and social interventions in responding to the grave harm differentially affecting all populations (victims, offenders, families, communities) impacted by adolescent sexual abuse.

CHAPTER FOUR

RELATIONAL THEORY

Relational theory is fundamentally about the centrality of relationships in psychological development and therapeutic change. Relational theory has been described as a "loose coalition" of theories, which cannot be reduced to a singular model (Wachtel, 2008), as it has evolved from and integrated concepts across schools of psychoanalytic thought. Greenberg and Mitchell's 1983 publication of *Object relations in psychoanalytic theory* is often cited as a foundational watermark in the theory's development. This text consolidated emerging trends within psychoanalysis and applied the term "relational" to this cohering movement, which they wrote, constituted a "relational turn" within the field (Bromberg, 1998; Segal, 2013). In this chapter, I provide an overview of the background and origins of relational theory, with particular attention to concepts most relevant to the subject of this study: the relational nature of human development, and relational understandings of transference-countertransference dynamics and enactment in clinical treatment. Next I will provide an overview of key trends in the empirical study of relational theory. Finally, I will discuss ways in which relational theory may be applied to treatment with juvenile sex offenders.

Overview of Relational Theory

Individual Development in Relational Context.

With *Object relations in psychoanalytic theory*, Greenberg and Mitchell (1983) synthesized developments within psychoanalysis going back to Ferenczi, Fairbairn and others, drawing together principles from object relations, interpersonal and self-psychology,

intersubjective theory—as well as influences from other fields including constructivism and gender theory (Bromberg, 1998; Arnd-Caddigan, 2003). Early object relations theorists broke ground for the principles of relational theory with the view that libidinal impulses—the engine, in classical analytic theory, of human psychosexual development, composed of intrinsic sexual and aggressive drives—was not simply pleasure-seeking, but object-seeking. Challenging Freud's pleasure principle, object relations theorists proposed that the primary psychic motivation underlying human behavior is the need to maintain primary relational attachments (or *"objects"*), despite the pain and harm that they may cause. Growing out of the work of Melanie Klein, Harry Stack Sullivan, W. Ronald D. Fairbairn, Donald Winnicott, and others, object relations theory emphasizes that early object relationships are internalized and become an emotional template for personality development and relationships over the life course. In this view, individual emotional life is fundamentally shaped by internal and external relationships to primary objects, which shape one's sense of self and self-other relatedness (Flanagan, 2011).

More broadly, object relations theorists contributed to the evolving notion within psychoanalysis of the ways in which the early relational context provides the foundation for a child's development—physiological, cognitive, and psychological. These patterns of object relatedness, particularly during formative childhood years, shape an individual's experiences—conscious and unconscious—as they move through life (Carey, 1997). Significantly, object relations builds on attachment theory in emphasizing the importance of early attachment in providing the context for child development, including the developmental tools related to self-regulation, symbolization, and interpretation and expression of affect (Blaustein & Tuber, 1996).

Scottish psychoanalyst W. Ronald D. Fairbairn's work with abused children led him to observe the extent to which children form strong attachments to their primary caregiver(s), even

in cases of severe violence and abuse (Mitchell & Black, 1995). Building on Melanie Klein's conceptualization of internalized objects, Fairbairn further developed the idea that object-relationships (both 'real' and internalized) are central to individual psychological motivation and psychopathology (Fairbairn, 1943). While preserving elements of Freud's model (namely the structural theory of the mind), Fairbairn argued that relationships—maintaining connection with important object relationships—supersede libidinal impulses as the animating force of individual development. Further, Fairbairn critiqued Freud's central theory of repression, noting that Freud himself considered 'the doctrine of repression [to be] the foundation-stone upon which the whole structure of psychoanalysis rests'" (Fairbairn, 1943, p. 60). For Fairbairn, repression was not a response to guilt surrounding intolerable Oedipal fantasies (as it was understood by classical psychoanalysis at the time), but was rather a defensive means to preserve critical object relationships. Rather than a guilt-based intrapsychic response to fantasied content, Fairbairn understood repression in relation to a child's actual lived experience; primarily as a response to intolerably bad objects, the "badness" of which must be repressed in order for the child to maintain a relationship with those objects, both 'real' and internalized (Fairbairn, 1943).

Further, Fairbairn theorized that traumatic experiences and memories are repressed because they represent a relationship with a bad object, a relationship, moreover, which evokes potent feelings of shame. Shame, Fairbairn explains, is particularly virulent in childhood, where identification is the basis for all object-relationships; "it follows that, if the child's objects present themselves to him as bad, he himself feels bad…" (Fairbairn, 1943, p. 64). In this way, children who have experienced relational trauma, particularly at the hands of a caregiver whom they are dependent on, tend to internalize the shame and "badness" of what was done to them, "splitting off" this badness from the bad object in order to relate to the needed caregiver as a

"good object". In Fairbairn's famous formulation, "it is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil" (Fairbairn, 1943, p. 66). As Fairbairn and others after him have observed, this defensive process is often what allows a child to survive, psychologically, in the immediate-term, though this often contributes to longer-term consequences. Fairbairn writes: "Outer security is thus purchased at the price of inner insecurity; and [the child's] ego is henceforth left at the mercy of a band of internal fifth columnists or persecutors, against which defences have to be, first hastily erected, and later laboriously consolidated" (Fairbairn, 1943, p. 65). For Fairbairn, this ego-defense against internalized bad objects—repression—predates any secondary defensive processes that may develop into subsequent psychopathology.

Both Fairbairn's contribution to object relations theory generally, and his development of the ideas of repression, specifically, have been adapted into contemporary relational theory. Like his contemporary, Pierre Janet, Fairbairn's conceptualization of the repression of internalized bad objects presaged (and contributed to) subsequent theories of dissociation as a defensive response, in particular, to complex relational trauma. While Fairbairn's model maintained pieces of classical Freudian theory, his ideas on children's defensive use of self-blame, the internalization and identification with the aggressive or abusive object, as a way to maintain attachment to needed caregivers in abusive circumstances, has continued to inform relational thinking on these interpersonal and intrapsychic processes.

Though heavily influenced by, and incorporating elements of, object relations, relational theory differs in several ways from this and other earlier psychoanalytic schools of thought. While relational theory shares object relations' emphasis on the importance of early relational matrices in individual development, relational thinkers tend to understand formative relational

patterns as influential, though not deterministic of, interpersonal patterns over the life course (Mitchell, 1988). Importantly, relational thinkers have challenged the purported dichotomy within psychoanalytic schools of thought between the objective or external reality of a patient's life, and the fantasied elaborations of the internal object world. As Davies (1996) articulates,

> relational analysts look to the patient's early life—to formative interpersonal context—in order to understand each individual's unique system of elaborate, internalized fantasy and the ways in which such fantasy organizes and informs the individual's particular organization of experience and generation of meaning (p.554).

In contrast to a classical analytic view of a linear arc based in endogenous fantasy, relational theory views human development as unfolding in a dynamic, dialectical relationship between internal, external, and interpersonal experience, and the generation of meaning through fantasy. Further, relational thinkers have extended this intra- and inter- psychic relational matrix to include larger social relations such as race, gender, power, and culture (Mitchell, 1988).

Another relevant distinction between relational and earlier psychoanalytic theories concerns the differing interpretations of dissociation and repression. Jody Messler Davies and Mary Gail Frawley (1992, 1994) have, in particular, developed and integrated relational theory and practice in working with dissociative phenomena. In contrast to classical theorists, Davies and Frawley (1992) understand dissociation not as a regressive defense against overwhelming feelings—or "drive derivatives" associated with earlier trauma—but rather as a process that "preserves and protects" the entire internal object world associated with the trauma. Building on and modifying Fairbairn's earlier observations, Davies and Frawley theorize that it is not only the "bad parts" of self-other representations which are split-off, internalized or repressed. Rather, it is the entire traumatogenic internal object world with the attendant ego states, memories, cognition, and affect, that is split-off from other structures of self-organization (Davies & Frawley, 1992). Davies and Frawley further clarify that unlike in the classical

topographical or structural model, where traumatic memories are repressed and driven underground, dissociation involves the splitting-off of traumatic memories into fragmented self-states, which alternate "in a mutually exclusive pattern" with other ego states (p.8). As will be discussed more fully below, these developments in relational theory have important implications for clinical practice, particularly in cases involving trauma and dissociative phenomena.

Key Principles of Relational Clinical Practice.

Relational theory's emphasis on the interpersonal dimension in human development is paralleled in the theory's views of therapeutic action in clinical practice (e.g., Safran, 2003). But what is the nature of this interpersonal encounter to which relational theory refers? How is it different, for example, than the theory of change and the therapeutic relationship in other contexts, from fin-de-siècle Vienna to the hundreds of permutations of psychotherapy practiced today? The "relational turn" encompasses ongoing and robust debates within psychoanalysis, and enlarges the conversation about concepts central to its theory and practice including the nature of reality, theories of mind, instinctual drives versus interpersonal relationships, and knowledge and authority in the treatment relationship.

Stephen Mitchell, (1998) who was a central figure in the development of relational theory, described the influence of the "intellectual revolutions" throughout the latter part of the 20th century —including developments in feminism, constructivism, and postmodern theory— upon traditional institutions and authority, including psychoanalysis. These social, political currents challenged the gendered and positivist underpinnings of classical psychoanalytic practice, including the nature of the therapeutic relationship. As Mitchell (1998) has written, Freud's view of the expertise of the analyst vis-à-vis the patient was consistent with the

prevailing epistemology of his historical location; "[for Freud], the patient's mind was part of nature, a particular part of nature that the analyst knows more about than anyone else" (p.12). In this way, the task of the analyst was to "uncover" and interpret the dynamics of the patient's mind as they manifest in the transference. In this classical view, the analytic stance required technical neutrality—a detached, objective, stance—to allow the transference to emerge without interference from the analyst.

Constructivist critiques have challenged the theory of mind underneath the idea of technical neutrality, arguing that the subjectivity of the therapist is inevitably present in the treatment relationship and that the mind is not a pre-organized, static formation, but an intricately and intersubjectively dynamic one which can be understood "only through a process of interpretive construction" (Mitchell, 1998, p.16). Crucially, as Mitchell and other relational thinkers contend, this process of interpretive construction applies to the conscious and unconscious mental processes of both patient *and* therapist as they come to be known in the therapeutic relationship. In concert with feminist critiques of the use of power and the gendered implications of the classical analytic stance—and classical psychoanalytic theory more broadly (Benjamin, 1995)—the "relational turn" fundamentally re-conceptualized the treatment relationship, emphasizing above all, the influence of both subjectivities involved. Relational thinkers such as Mitchell,[16] have elaborated on this view, emphasizing the asymmetrical, and yet co-constructed, nature of the therapeutic process in which the conscious and unconscious experiences of both analyst and analysand are continually and dialectically interacting, and being experienced and interpreted by the two subjectivities in the room.

[16] For further reading of key relational perspectives on the treatment relationship, see also: Aron (1991), Bromberg (1993), Davies (2004), and Safran (2003).

Enactment, Dissociation and Self-States.

This evolving view of the therapeutic process—what has been described as a paradigmatic shift from a "one-person psychology" to a "two-person psychology"—has created openings for new understandings of transference-countertransference dynamics central to relational therapy. Recognizing that the therapist's subjectivity is inevitably present in the treatment process, relational therapy places greater attention and emphasis on transference-countertransference dynamics. The exploration of the dynamic interplay between both parties' conscious and unconscious participation is not only seen as useful, but as an essential component of treatment (Aron, 1991; Berzoff, 2011; Safran, 2003). In contrast to classical and some postclassical treatment perspectives, relational theory views therapeutic action—the mechanisms of change in psychotherapy—to center more on the distinctiveness and dynamic experience of the clinical relationship over, or in addition to, the technical focus on interpretation and insight (Safran, 2003). Further, relational theorists emphasize the uniqueness of the relational context within which the meaning of any given interpretation will be experienced. In this view, the technical features of any interpretive intervention cannot be separated from the conscious and unconscious dimensions specific to the complex relational matrix between the two people in the room at any given moment in treatment (Safran, 2003).

This dynamic interplay between the subjectivities of therapist and client has been described as a relational *enactment*—or, the process in which "inchoate" experience is enacted in the transference-countertransference field (Bass, 2003). As Bromberg (1998) explains, *enactment* is the vehicle by which "unthinkable" or as yet unformulated, un-symbolized, dissociated experience can become associatively accessed, can be made "thinkable." This relational view of enactment and therapeutic action requires distinct modes of engagement from

the therapist. Crucially, the analyst must "create a therapeutic environment that allows this enactment to occur", and to participate in and experience with the patient, this manifestation of the patient's inner reality (Bromberg, 1993, p.152). Bromberg stresses that therapeutic change is not simply achieved through verbal (conceptual) interventions, but also through the experiential (perceptual) process which patient and client must live through together through careful attention to enactments in the treatment relationship.

This theory of the therapeutic utility of relational enactment has evolved in tandem with conceptualizations of the nature of "the self". Discussing the movement away from notions of a unitary self toward a conceptualization of a multiplicity of states of consciousness, Bromberg writes of a shift "toward a view of the mind as a configuration of discontinuous, shifting states of consciousness with varying degrees of access to perception and cognition" (Bromberg, 1998, p. 225). Emerging in part from recent developments in theories on the nature and impact of trauma to the psychological self, relational theorists have explored the possibility that a multiplicity of self-organizations and unconscious process may more accurately describe the psychic structure of the mind more generally, with dissociative, traumatogenic phenomena as one portion of a wider continuum (Davies, 1996).

This renewed theorizing on the multiplicity of unconscious process generally, lends critical insight into the impact of trauma to an individual's sense of self.[17] Unlike a topographical (horizontal) model of stratified layers of consciousness—in which disturbing content is repressed to the unconscious—relational thinking has developed a view of a multiplicity of self-experiences where dissociation is understood as the vertical splitting of whole

[17] This view of the multiplicity of unconscious process represents a "renewed" theoretical project, in the sense that Davies (1996) describes the "pre-analytic" roots—in the early writing of Breuer and Freud and Pierre Janet—of contemporary relational theories of mind.

self-other configurations. Relational theorists posit that under "normal mental functioning", the degree of connectedness among self-states exists on a continuum, with more or less access to conscious awareness at any given time (Bromberg, 1998). Dissociation describes, in part, the relative degree of connectedness along this continuum.

Together, these developments—the conceptualization of dissociation, self-states and relational enactment—represent core tenets of relational theory and practice. As will be explored later in this chapter, these concepts provide unique etiological and treatment perspectives for working with adolescent sexual offenders.

Summary of Trends in Empirical Studies of Relational Theory

Very little empirical literature is available specifically investigating the use of relational theory in working with trauma and dissociation, much less in working with sexual offenders of any age. Generally speaking, empirical studies have largely focused on cognitive behavioral treatment approaches in the treatment of trauma (Gleiser, 2003; Hirose, 2009;Wolf & Alpert, 1991). Although this researcher has not encountered empirical studies looking specifically at psychoanalytic relational treatment with sexual offenders, the following is primarily an overview of empirical studies on the use of relational theory with survivors of sexual abuse, as well as empirical literature concerning traumatogenic dissociation and reenactment. This discussion will focus on the potential relevance of this literature to clinical work with juvenile sexual offenders.

Levendovsky and Buttenheim (2000) present a case study on the use of relational theory and trauma theory in the treatment of a latency age incest survivor. This study is particularly relevant in that the authors adapt Davies and Frawley's (1994) clinical theory on relational psychoanalytic treatment of adult survivors of childhood sexual abuse, to treatment with

children. As is often necessary in working with children, this case study describes interventions encompassing many spheres of the client's life (parent/caregiver guidance, school, Department of Social Services and individual psychotherapy). This approach ties to findings discussed above on the preliminary positive outcomes in studies of multisystemic therapy with JSOs. This study is also illustrative in the authors' approach to reenactment phenomena as they emerged in the course of treatment. Diverging somewhat from the approach to reenactment articulated by Davies and Frawley (1994), Levendovsky and Buttenheim (2000) advise clinicians to avoid or minimize the manifestation of reenactment phenomena in treatment with children. This points to significant challenges to the adaptation of some aspects of relational treatment developed for adult survivors of CSA in treating children and adolescents.

One of the few pieces—empirical, theoretical, or otherwise—discussing the use of psychodynamic treatment of sex offenders is a theoretical essay about the use of self psychology in individual and group psychotherapy with adult sex offenders. Anechiaricho (1990) contrasts classical drive theory with self psychology in his interpretation of the development of sexual aggression. Anechiaricho does not discuss the potential role of childhood trauma in the etiology of sexual aggression. Rather, he locates its origins in the failure of the childhood environment to adequately meet the needs of the developing self; the fragmented self, then, becomes organized around sexual and aggressive drives as an attempt to regulate self esteem and avoid total self-fragmentation (Anechiaricho, 1990). Based in this view of the etiology of sexual aggression, Anechiaricho's treatment considerations are based in a traditional self psychology model—attending to the unmet developmental, self-object needs of the patient through individual and group psychotherapy.

As there are few empirical or theoretical studies looking specifically at traumatic reenactment, the literature on revictimization offers insights that may be adapted to the study of reenactment. In a synthesis of theories of traumatic repetition, Gleiser (2003) defines reenactment alongside revictimization as two forms of traumatogenic repetition phenomena. Whereas revictimization refers to the increased prevalence of rape, assault and abuse among adult victims of CSA, reenactment refers to the direct replication of abusive experiences in the victimization of others (Gleiser, 2003). Extensive epidemiological data demonstrates the high prevalence of revictimization among CSA survivors. A representative study found that "CSA survivors were 6.76 times more likely to be a victim of attempted rape and 4.41 times more likely to be a victim of rape than their non-abused counterparts" (Gleiser, 2003). Similar to findings discussed in Chapter Three showing that the relational context of the abuse may compound the psychological harm, Gleiser (2003) also reports findings showing that survivors of incest were 9.35 times more likely to be victims of rape as adults than were their non-abused counterparts. Further, preliminary research has found a correlation between the specific acuity of PTSD symptomatology and higher prevalence of revictimization among CSA survivors during a 10-week period (Gleiser, 2003).

Speaking specifically of trauma survivors, Gleiser (2003) suggests that entrenched, unrecognized dissociative patterns may contribute to the evidently increased risk of revictimization. Recognizing the perniciousness of a blame-the-victim mentality, Gleiser is careful to note that inquiry into the possible role of unconscious dynamics—such as dissociation—for which survivors of CSA may be disproportionately vulnerable, and which may heighten the risk of revictimization, does not imply that a victim is responsible for being victimized. Indeed, further research is greatly needed into whether offenders may exploit

perceived vulnerabilities in people with prior histories of abuse. With this critical awareness of the greatly differential meaning for victims and offenders, this study indicates the need for further research into the possible role of dissociation for both revictimization and reenactment phenomena.

As mentioned in the previous chapter, van der Kolk (1989) conducted one of few empirical studies into traumatic repetition phenomena. Van der Kolk reported the wide-ranging diversity of repetition phenomena in which trauma may be repeated on behavioral, emotional, physiologic, and neuroendocrinologic levels. Van der Kolk notes that hyperarousal, and the consequently impaired capacity to modulate physiological arousal, is a widely documented trauma response, particularly to stimuli reminiscent of the trauma (i.e., triggers). Van der Kolk suggests that this tendency toward hyperarousal and impaired self-regulation, may lead to a tendency to experience later stresses somatically, as physiologically and emotionally overwhelming experiences. Van der Kolk writes:

> Thus, victims of trauma respond to contemporary stimuli as if the trauma had returned, without conscious awareness that past injury rather than current stress is the basis of their physiologic emergency responses. The hyperarousal interferes with their ability to make calm and rational assessments and prevents resolution and integration of the trauma. They respond to threats as emergencies requiring action rather than thought (p. 395).

Further, just as external stimuli may cause significant autonomic arousal, where an individual experiences a current stressor as though it were an earlier trauma, van der Kolk describes how the inverse is also common: experiences of heightened physiologic arousal often precede re-experiencing phenomena—such as visual and motoric reliving experiences, nightmares, flashbacks, and reenactments—among traumatized people.

Van der Kolk integrates this bi-directional chain of hyperarousal and traumatic re-experiencing with ethological and behavioral research on state-dependent learning. Theories of

state-dependent learning may explain how traumatic memory is encoded in states of hyperarousal, where it is stored or dissociated and "only returns fully during renewed terror" (van der Kolk, 1989, p.405). The relational concepts of "self-states" may articulate in another terminology, this same process by which alternating, mutually exclusive "state-dependent" self-other experiences—and the encoded affects, memory, and cognitive processing—are dissociated and relived in the aftermath of trauma. These overlapping theories of self-states and state-dependent learning expands upon the victim-victimizer research discussed in the previous chapter, which shows that juvenile sexual offending behavior is highly reflective of the offender's own victimization experience (Burton, 2003; Veneziano, et al., 2000).

Application of Relational Theory to Treatment with JSOs

Relational understandings of dissociation, which have primarily been applied to clinical practice with trauma survivors, offer important insight for understanding and treating adolescent sexual abusers. Chapter Two provided a brief overview of the genealogy of psychoanalytic perspectives on dissociation from Pierre Janet to contemporary relational thinkers. Building on this earlier review of the clinical literature, this section will specifically look at the etiological and treatment implications that may be found in the study of dissociative and reenactment phenomena. Following this return to the literature on dissociation, this section will more fully explore the specific treatment framework developed by Jody Messler Davies and Mary Gail Frawley as it pertains to understanding and adapting the model to working with adolescent sexual offenders.

As reviewed above, relational theorists conceptualize dissociation as a defensive process which aims to protect the person from traumatic memories and associated affects, meaning, self-

other representations, and regressive fantasies these memories trigger (Davies & Frawley, 1992, 1994). Davies and Frawley (1992) consider dissociation to be intrinsic, and in fact, pathognomic, to the intrapsychic structure and organization of adult survivors of CSA. Discussing the work of David Spiegel, Davies and Frawley (1994) note that in cases of incest, in particular, an initial dissociative response is reinforced by the double bind children face in which they must essentially "'become two contradictory people simultaneously' while being prohibited from addressing the contradiction" (p.32). Over time, this dissociative organizing pattern can become consolidated into a psychological structure composed of alternating self-states with limited or fractured associative accessibility. Integrating the psychobiological, attachment and relational literature on trauma, Davies and Frawley (1994) find that particularly in cases of persistent childhood trauma, which utterly floods the organizing, synthesizing, symbolizing functions of the ego, traumatic experiences "lie encrusted in a primitive core of unspeakable terror and phenomenologically meaningless panic, intrusive ideation, and somatic sensation" (p.45). As such, these traumatic experiences are not readily available to associative, cognitive or verbal processing.

Although Davies and Frawley are speaking specifically of survivors, per se, their integration of the literature on dissociation, and the psychobiological symptomology among adult survivors of CSA appears highly consistent with the literature reviewed in the previous chapter on the histories of persistent, complex trauma among adolescents who have committed sexual offenses. For those adolescent sexual offenders who are also survivors of CSA, can this understanding of the ways in which persistent childhood trauma may be stored in pre-formulated, somatic states of terror and panic, contribute to the etiology of juvenile sexual offending? For example, the victim-victimizer research (Burton, 2003; Veneziano, et al., 2000) shows the

striking degree to which adolescent sexual offenders typically replicate their own experiences of victimization in terms of the age, gender, and degree of relatedness of their victim(s), and the modus operandi of their abusive behavior. This raises important etiological questions concerning the possibility that this offending behavior may be a severe somatic-behavioral manifestation of pre-formulated traumatogenic experience and state-dependent re-experiencing phenomena. It appears conceivable that in some cases, a young person's sexual offending behavior may have originated in the face of an acute trigger, such as being alone with a child or peer who evokes the offender's own victimization, and feelings of overwhelming panic, intrusive ideation and somatic sensation and ultimately to actual replication of violence and abuse. Further research is needed to develop this prospective hypothesis.

In their extensive work with adult survivors of CSA, Davies and Frawley have developed a framework for the archetypal transference-countertransference configurations which emerge in treatment, an understanding of which, they argue, is necessary for therapists to enter into the relational matrix and together come to know (and ultimately integrate) the patient's dissociated self-states (Davies & Frawley, 1992, 1994). In working with this patient population—which in their practice with adult survivors of CSA has almost exclusively been women—Davies and Frawley have observed a common clinical phenomenon they describe as the presence of two prominent self-states in their patients' ego-organization. They have found that patients will often initially present with the appearance of an adaptive, well-functioning, socially competent adult-self, which hides and protects a fragile, dissociated child-self. This child-self, they suggest "has a different ego structure, a more primitive and brittle system of defenses, a fuller and more affect-laden set of memories and has clearly become the repository for the patient's intense, often overwhelming rage, shame, and guilt" (Davies & Frawley, 1992, p.17). Describing the

challenges to creating the conditions in which such vulnerable self-states may come to be known in treatment, Davies and Frawley note that only after careful testing, and slowly over time, will this child-persona begin to emerge. Within this model, a critical component of treatment is the acceptance and integration of the adult and child personas' experiences that are otherwise caught in a "constant battle with the ever-ready tendencies toward dissociation and disorganization" (1994, p. 74).

Particularly relevant to the application of their approach to the treatment of JSOs, Davies and Frawley (1994) describe another dissociative self-state, the "adolescent persona", which they have observed in their practice with adult women survivors. The authors find that this "adolescent persona" often appears as the dissociated child-self is beginning to emerge in treatment, threatening to overwhelm the adult persona. This adolescent protector-self, they write, attempts, above all, to obscure and prevent the emergence of the child-self and the associated traumatogenic memories. In attempting to do so, the adolescent aspect of the personality utilizes the only familiar or available means of exercising control, displaying the cruel and abusive methods of control experienced as a child; "The adolescent persona is, in essence, the clinical manifestation of the sadistic introject in its dissociated adult form" (p. 23). As the therapist and patient enter into these dissociated internal-object worlds, and as the patient witnesses their own dissociative processes within the holding environment of the treatment relationship, these confounding experiences can begin to be understood and integrated.

Davies and Frawley are describing the ways in which the patient's dissociated self-object world comes to be known through the revolving transference-countertransference configurations. A question that emerges from this model is: to what extent do these dissociated self-states manifest outside the treatment relationship? Can we understand this dissociative pattern in the

sexually abusive behavior of some adolescent sexual offenders? Is the victimization of others a severe dissociative reenactment of the "sadistic introject" Davies and Frawley refer to as the adolescent-persona in the clinical context with adult survivors?

While these questions remain speculative at the moment—and raise further clinical and pragmatic questions and challenges—Davies and Frawley's framework suggests significant treatment implications for working with JSOs. A key finding from their work with traumatogenic dissociative phenomena, is the recognition that particularly in cases of persistent childhood abuse, pre-formulated, pre-symbolically or narratively integrated traumatic experiences "exist outside the usual domain of recalled experience, unavailable to self-reflective processes and analytic examination" (p.45). In cases of severe dissociation, then, it is not enough merely to operate in the verbal, symbolically encoded terrain of narrative memory. Davies and Frawley (1994) make a strong case for an integrative approach, which creates a relational arena in which dissociated experience can become known and worked through. Fundamentally, Davies and Frawley (1992) assert the essential role of reenactment in the treatment of traumatogenic dissociative phenomena. Only by entering into, rather than interpreting, the patient's dissociated internal object world—as it is enacted in the transference-countertransference—can the patient and analyst come to recognize and find resolution to the traumatic, fragmenting experience at the heart of the presenting psychopathology.

Further, not only is it essential to work within the relational reenactment in treatment, Davies and Frawley (1992) caution that to approach treatment with severely dissociative patients exclusively based on verbal interpretation may actually preclude the emergence of dissociated self-states, and thereby may actually interfere in the recovery and working through of the essential traumatogenic duality that is at the root of the patient's symptomology. If we are to

take seriously the role of severe dissociative phenomena in sexual offending behavior, it is possible that currently predominant CBT-based treatment—focused as it is on verbal and cognitive processing—may (unwittingly) reinforce dissociative patterns.

Relational theory offers a conceptual basis to understand how abusive reenactment may develop as one potential symptom of sexual trauma. If reenactment is in important respects a repetition of prior victimization, relational theory challenges predominant conceptions of sexual offending exclusively as an individual pathology. Transformative justice, then, further extends the scope of this analysis. How do histories of colonial violence, genocide, and other systems of domination which affect whole communities, differentially but universally, reinforce individual forms of domination such as intimate violence?

CHAPTER FIVE

TRANSFORMATIVE JUSTICE

"[S]ome lessons you are taught as a child should not be passed on … A set of lessons destined to repeat unless you are granted the grace of insight and choose to embrace new learning" (from He Korero Iti (A Small Story), the StoryTelling & Organizing Project, a project of Creative Interventions, Kim, 2010, p. 194).

Within the last fifteen years there has been an upsurge in community-based organizing rooted in the principles of Transformative Justice and Community Accountability. This growing movement encompasses a diverse range of formal and informal projects and organizations which variously employ the terms Transformative Justice, community accountability, and community-based violence intervention. A unifying feature across this movement is a commitment to creating alternate responses to interpersonal violence that build community capacity to heal from trauma and to transform the conditions in which trauma and violence occur. There is a growing literature on this and related work happening around the world, and many of the US-based movements participate in transnational networks and alliances (Sudbury, 2005). The study presented here is primarily focused on TJ as it is being developed in the US. Specifically, this discussion of TJ is anchored in the thinking and analysis found in two texts: *Gender Violence and the Prison Industrial Complex*, written in a collective process organized by Critical Resistance and Incite! Women of Color Against Violence, and GenerationFIVE's document *Toward Transformative Justice* (Sudbury, 2005; Kershnar, et al., 2007).

Transformative Justice and the related model of Restorative Justice are two systemic ecological approaches for responding to harm and conflict. Restorative Justice programs are more widely developed than Transformative Justice, with programs throughout North America, Europe, Australia, and New Zealand, including victim-offender reconciliation programs; family

group conferences; and sentencing circles, which are most widely practiced among indigenous communities in Canada. Transformative Justice builds on the principles and practices of Restorative Justice, extending those principles beyond the criminal legal system (Cooley, 1999; Morris, 2000). Whereas the aim of Restorative Justice interventions into harm and conflict is to restore justice to all those affected by the harm, Transformative Justice is concerned with the conditions of injustice in which individual instances of harm take place (Kershnar, et al., 2007; Kamya & Trimble, 2002). Fundamentally, Transformative Justice is a liberatory approach to ending violence and is premised on three core principles: 1) Individual justice and collective liberation are mutually supportive and interconnected; 2) Transforming the conditions that allow violence to occur is necessary for achieving justice in individual instances of violence; and 3) State and systemic interventions—including the criminal legal system and child welfare system—fail to promote justice, and in fact, perpetuate cycles of violence (Kershnar, et al., 2007).

Origins of Transformative Justice: Women of Color Feminism

The feminist and feminist antiviolence movements of the 1970s politicized the largely hidden and privatized experiences of domestic violence, sexual violence and child sexual abuse, linked these forms of violence to patriarchal social relations and made organizing against interpersonal violence a core tenet of the feminist movement (Whittier, 2009; Kim, 2010). The Transformative Justice movement is in certain respects, an outgrowth of this earlier organizing. Transformative Justice has emerged as a corrective or alternate response to what many in this movement see as the limitations and contradictions of mainstream antiviolence organizations (Smith, 2005; Sudbury, 2003). Many of the progenitors of the Transformative

Justice/Community Accountability movements were feminists of color who had been active in both the prison abolitionist[18] and anti-domestic violence/anti-sexual assault movements throughout the 1980s and 1990s and who challenged both the marginalization of women of color within the movement, as well as within the analysis of violence itself, which centered the gender-based nature of violence to the exclusion of an analysis of racism and colonization (Sudbury, 2003).

As the Transformative Justice/Community Accountability literature describes, these material and theoretical contradictions intersected with federal policy priorities as mainstream antiviolence organizing dovetailed with the build-up of the prison-industrial-complex throughout the 1990s (Smith, 2005; Sudbury, 2003). Andrea Smith—co-founder of Incite! Women of Color Against Violence, an organization of radical feminists of color working to end state and interpersonal violence—has documented the ways in which mainstream antiviolence work aligned with the "tough on crime" legislation of the 1990s, and the racist and colonial build up of the criminal legal system (Smith, 2005). Smith notes that the funding imperatives of the 1994 Violence Against Women Act were one component of this larger shift (Smith, 2005). Based in this analysis, TJ organizers have called for, and developed, strategies that address interpersonal acts of gender violence while simultaneously addressing state violence (Smith, 2005). The intricate and dialectical relationship between interpersonal and structural or state violence is central to the analysis and principles of Transformative Justice/Community Accountability movements.

There is an extensive body of literature theorizing the build up of the prison-industrial complex (PIC) from the 1970s onward (CR10, et al., 2008; Davis, 2003; Gilmore, 2007; Parenti,

[18] Critical Resistance defines abolition as "a political vision that seeks to eliminate the need for prisons, policing, and surveillance by creating sustainable alternatives to punishment and imprisonment" (Sudbury, 2003).

1999; Sudbury, 2005), and the ways in which the logics of neoliberalism—including a renewed reliance on policing and incarceration—have become embedded in the mainstream anti-violence movement (Incite!, 2006, 2007; Richie, 2012). Transformative Justice and Community Accountability movement scholars and activists have also theorized that the growth of the PIC is not only a material crisis, but an epistemic crisis as well, that frames the priorities and political imaginations of anti-violence organizations (Rojas, et al., 2012). It is into this site of epistemic crisis, that Transformative Justice movements have sought to revitalize collective imaginations, creating theory and concrete tools and practices toward building a world without violence.

As Mimi Kim, one of the founders of the community accountability resource center Creative Interventions, based in Oakland, California, (2010) writes, they and others in this movement have sought to "excavate the wisdom embedded in otherwise neglected and forgotten community memory to inspire and inform us on the creative and courageous efforts of everyday people". As Kim makes clear, Transformative Justice movements are not so much a "new model" as they are efforts to strategically organize and cultivate under-recognized theory and practice emerging from marginalized communities of the past and present.

As a model for addressing intimate and community violence, TJ has developed from the principles and practices of Restorative Justice (Cooley, 1999). The concepts at the core of TJ, however, draw from a broad social history largely informed by women of color feminisms, and in particular, the work of black feminists who have long theorized the relationships between intimate violence and structural or state violence. Such analysis can be traced to anti-lynching writer and organizer Ida B. Wells who articulated that rape and lynching were both forms of racial and sexual violence (Rojas Durazo, Bierria, & Kim, 2012; Smith, 2005). Such a formulation is central to a key principle of TJ, which understands sexual violence to include not

only individual acts such as sexual assault and rape, but also "a wide range of strategies designed not only to destroy peoples, but to destroy their sense of being a people" (Smith, 2005, p. 3). Andrea Smith, a Native American scholar and activist, has elaborated this intersectional theory of sexual violence that is central to the theory and practices of Transformative Justice. By defining sexual violence beyond individual, putatively isolated, incidents, and understanding the ways in which entire communities have been victims of gender and sexual violence, Smith pushes the lens beyond an individual victim and perpetrator and beyond a treatment paradigm that addresses violence exclusively at the level of a single person and a single generation.

In a distinct, though related, analysis, Angela Davis has written on the ways in which sexual violence by white men against black women was institutionalized as a weapon of slavery (Davis, 1975).[19] Davis further calls attention to the ways in which this historical legacy forms the social context of continued raced and gendered oppression and violence against black men and women including, as one example, the disproportionality in conviction rates of black men charged with sexual violence from 1930-1967 (Davis, 1975).

Key Principles and Trends

Individual and Collective Trauma.

In contrast to western mental health approaches to sexual abuse, which locate the individual as the site of pathology and intervention, Transformative Justice views individual incidents of sexual abuse through an intersectional analysis in which entire communities and

[19] For a discussion of the distinct and related histories of sexual violence against Native American and African American communities, see Smith, A., (2005). Sexual violence as a tool of genocide, in *Conquest: Sexual violence and American Indian genocide.* Cambridge, MA: South End Press; and, Smith, A. (2006). Heteropatriarchy and the three pillars of white supremacy: Rethinking women of color organizing. In Incite! Women of Color Against Violence. (Ed.). (2006). *Color of violence: The incite! anthology.* Cambridge, MA: South End Press.

multiple generations have been impacted by interlocking forms of violence (Smith, 2005). Drawing on the writing of anti-colonial theorist Frantz Fanon, Andrea Smith theorizes the gender violence of North American colonialism and its lasting impacts in Native communities. Both Fanon and Smith assert that colonial systems (and the gender violence inherent in them) produce the destructive behavior which is expressed in multiple forms: the phenomena of interpersonal violence, then, cannot be understood solely in terms of individual pathology (Smith, 2005).

Within the much larger history of colonial violence in North America, Smith has written extensively about the residential school systems within indigenous communities in the US and Canada (Smith, 2005; 2007). The residential school system was a U.S. government program throughout the 19th and 20th centuries in which over 100,000 Native American children were forcibly removed from their homes and sent to Christian boarding schools (Boarding School Healing Project, n.d.; Smith, 2007). Smith argues that these schools represent a form of gender violence that inculcated patriarchal norms and destroyed native women's leadership in their communities. Smith writes that children who had been institutionalized in the boarding schools "began to mimic the abuse they were experiencing" and that in the generations following the first boarding schools, abuse became endemic in Native communities (Smith, 2005, p. 43).

For Smith and other scholars and activists within the TJ literature, an analysis of the role of distinct forms of colonial and racist violence, such as the boarding schools, is critical to the development of comprehensive strategies for ending gender violence that affect all people (Smith, 2005). Importantly, such an analysis requires that racist and colonial violence—including as they are marshaled in defense of victims of sexual violence—be taken into account in organized, long-term strategies to end sexual violence. Further, recognizing the broader

legacies of violence may help to lessen the shame and self-blame that is, in part, an outcome of the individualized interpretation of trauma (Smith, 2005).

This is crucial for the principles of TJ which are, in part, a response to principled differences with mainstream antiviolence organizations' reliance on the criminal legal system as a primary response to sexual and domestic violence (Smith, 2005). By conceptualizing the relationship of intimate violence and systemic race-based and gender-based violence, Transformative Justice requires an analysis of the way that responses to intimate violence themselves have contributed to the build-up of the criminal legal system and its disproportionate impact on poor communities and communities of color (Smith, 2005; Kershnar, et al., 2007).

Transforming the Root Causes of Violence.

Transformative Justice emphasizes the need to support both the immediate safety and long-term healing and reparations for survivors of violence *and* long-term accountability, healing and transformation for people who have abused (Kershnar, et al., 2007, p. 10). Fundamentally, TJ challenges the idea that there is an intrinsic or inherent pathology that causes someone to become abusive. TJ seeks to understand and transform the underlying conditions of violence that contribute to individuals enacting violence interpersonally. In holding the importance of accountability *and* maintaining the humanity of the offender, TJ recognizes their behavior as a) requiring a dedicated process of accountability and b) symptomatic and reinforcing of larger social conditions, and challenges the logic of "throwing people away", an underlying premise of incarceration. Rather, TJ challenges those concerned with addressing abuse to consider the healing of the offender—in a way that contributes to the remediation of the conditions which gave rise to the violent/abusive behavior—as an important goal in the remediation of the offense.

The State.

A central principle of Transformative Justice is the understanding of the state—through the historical and present day institutions and policies of slavery, colonization, policing and mass incarceration, immigrant detention, the criminalization of queer and transgender people, and the gendered violence of war—to be a primary source of, rather than a solution, to gender violence (Bhattacharjee, 2001; Kershnar et al., 2007; Kim, 2010; Richie, 2012; Ritchie, 2014; Smith, 2005; Sudbury, 2003). Therefore, TJ is concerned with the extent to which responses to intimate violence, such as the predominant interventions of a) denial, isolation and silence or b) individualized treatment for the victim (psychotherapy) and the offender (incarceration) reproduce the conditions underlying the incidences of violence themselves. A critique of the relationship between mainstream antiviolence organizations and the state, as well as pragmatic questions concerning how TJ organizations relate to state institutions are subject to much debate within the TJ literature (Kershnar et al., 2007; Kim, 2010; Smith, 2005). Fundamentally, TJ aims to build alternate solutions to violence that transform rather than reproduce what are understood to be underlying conditions of domination and violence (Kershnar et al., 2007; Kim, 2010).

Further, the TJ literature challenges the effectiveness of the prevailing model—the criminal legal system—to reduce the prevalence of interpersonal violence or foster safety (Critical Resistance, et al., 2003; Ross, 1996b; Smith, 2005). Specifically in terms of child sexual abuse, GenerationFIVE argues that both the criminal legal system and the child welfare system fail to offer real solutions to preventing or healing from interpersonal violence. These

prevailing interventions, in their view, "often leave individuals and families with partial solutions that open up trauma without actually transforming it" (Kershnar, et al, 2007, p. 23). While individuals and families are often re-traumatized in the course of investigations, TJ/CA practitioners argue that in the aggregate, this model has failed to decrease long-term rates of abuse, despite the exponential increase in overall rates of incarceration (Kershnar, et al., 2007).

Overview of TJ Organizing Today

Currently, TJ initiatives in the US have been most effective in articulating a critique of the prevailing models of intervention into intimate violence and outlining the goals and principles for the development of TJ as a viable model. Many programs are in the process of incubating the infrastructure that they see as necessary prerequisites of moving from theory to practice (Chen, et al., 2011; Kim, 2010).

In the United States, GenerationFIVE, an organization based in Oakland, California, has developed the Transformative Justice (TJ) approach specifically toward addressing child sexual abuse and other forms of intimate and community violence (Kershnar et al., 2007). GenerationFIVE has set a goal and a 125-year plan to end child sexual abuse within five generations. GenerationFIVE defines Transformative Justice as "an adaptable model that can and will address myriad forms of violence and the systems of oppression that violence enables" (Kershnar et al., 2007). GenerationFIVE defines the goals of TJ as a response to child sexual abuse to be: "1) Survivor safety, healing and agency; 2) Offender accountability and transformation; 3) Community response and accountability; and 4) Transformation of the community and social conditions that create and perpetuate child sexual abuse, namely systems of oppression, exploitation, domination, and State violence" (Kershnar et al., 2007, p. 51).

In collaboration with other community accountability organizations, GenerationFIVE developed a set of principles as guidelines in the application of Transformative Justice to interventions into incidents of intimate violence (Kershnar et al., 2007). The principles of TJ, according to GenerationFIVE (2014), are: 1) Liberation, 2) Shifting power, 3) Safety, 4) Accountability, 5) Collective Action, 6) Respecting Cultural Differences/Guarding Against Cultural Relativism, and 7) Sustainability. Research is needed into the application of this framework in interventions into incidents of CSA involving juvenile sexual abusers.

Empirical Studies of Transformative Justice

The empirical literature is limited as there has been little research published on the clinical application of transformative justice. One of the few studies on TJ is a qualitative study interviewing mental health clinicians trained in Transformative Justice about their perspectives on the use of TJ in CSA. Noting that the primary treatment of CSA is an individual mental health model, rather than a systemic model, this study found that "[p]articipants reported that prevailing interventions failed to address the complexity of CSA and therefore missed opportunities of intervention, such as using bystander leverage in holding offenders accountable to abstaining from abusing" (Hirschfield-White, 2010, p. 64). This is consistent with Smith's (2005) finding that the individualized treatment of intergenerational trauma contributes to shame and self-blame which inhibits people from seeking treatment and support.

Two additional key findings from Hirschfield-White's (2010) research on clinician's views on the application of Transformative Justice in cases of CSA are: 1) TJ provides a vision of hope and, 2) that bystanders are an untapped resource in CSA prevention and intervention. This vision of hope, participants reported, supported the capacity of providers to persevere

through the challenging clinical work surrounding CSA. Clinicians who participated in the study reported that "TJ made the incomprehensible understandable as no longer was CSA an uncontrollable behavior that was mysteriously acted out by bad people. Instead it was a definable and controllable phenomenon rooted in social conditions that could be changed" (Hirschfield-White, 2010, pp. 65-66). And finally, the study revealed the need for greater research into the potential role of bystanders in interrupting, and preventing incidents of CSA as well as the social norms and conditions which contribute to CSA. Hirschfield-White reports, "Key in this finding is using the leverage of social relationships to support and keep accountable the people surrounding a potentially abusive incident (Hirschfield-White, 2010, p. 66). Hirschfield-White (2010) highlights relevant literature on the empowerment of bystanders and the use of intimate relationships to enforce accountability and social norms; in the treatment of domestically abusive men (Miner and Munns, 2005) and in the treatment of youth violence, child maltreatment, and intimate partner violence (Sabol, Coulton, & Korbin, 2004).

Hollow Water Community Holistic Circle Healing.

As there are currently no published studies on the application of Transformative Justice in the treatment of JSOs, the empirical literature on Restorative Justice offer relevant findings to guide further research and practice. Hollow Water Community Holistic Circle Healing (CHCH), in the Anishnabe (Ojibwe) First Nations community known as Hollow Water outside of Manitoba, Canada, is one of the most established and most studied Restorative Justice programs in North America, and has specifically addressed cases of child sexual abuse and intergenerational trauma, as well as other forms of interpersonal violence and conflict. This is a distinctly Restorative Justice based program, in that it is integrated into the Canadian legal

system and the threat of incarceration is one component of the program's enforcement power. Despite critical differences that distinguish the Hollow Water CHCH from TJ, it is one of the most established and most studied programs and has operationalized principles that are encompassed within both TJ and RJ frameworks.

This holistic healing program was developed inadvertently after a community development project which had been initiated to address social issues related to drug and alcohol abuse, unemployment, and education. In its development, the program uncovered a widespread crisis of sexual abuse that had remained largely hidden until that time (Bushie, 1999). Berma Bushie, one of the founders of the CHCH, writes that the initial disclosure of sexual abuse in 1986 opened up a flood of sexual disclosures among people in the community. Members of the Resource Team "gradually discovered that as the blanket of alcohol abuse was removed, many of the people were holding on to acute anger, hurt and dysfunctional behaviour patterns that were related to sexual abuse or to some other violation that had been done to them in their past" (Bushie, 1999). Leaders of the CHCH reported that an initial disclosure of child sexual abuse and the beginning of what became the Circle Healing program, created an environment in which the taboo was broken and a striking number of disclosures of CSA were made to the team (Bushie, 1999).

The CHCH process is a holistic ecological model that includes victims, offenders, and bystanders and extended family members throughout the process. Set up in partnership between the CHCH and the courts, this multi-pronged approach is based in restorative justice circle processes according to the following 13-step protocol: 1) Disclosing 2) Establishing safety for the victim 3) Confronting the victimizer 4) Supporting the victimizer's spouse or parent 5) Supporting the family and community 6) Meeting of the assessment team with the police 7)

Conducting circles with the victimizer 8) Conducting circles with victim and victimizer 9) Preparing the families of the victim and the victimizer for the Sentencing Circle 10) Preparing the victimizer's family for the Sentencing Circle 11) Conducting a Sentencing Circle 12) Sentencing review 13) Cleansing ceremony (Sawatsky, 2009).

Participants and leaders in the CHCH program have reported that prior to the development of this alternative model, survivors, abusers and bystanders were less likely to disclose abuse because the consequences were so grave. As CHCH participants have written,

> the threat of incarceration prevents people from coming forward and taking responsibility for the hurt they are causing. It reinforces the silence, and therefore promotes rather than breaks, the cycle of violence that exists. In reality, rather than making the community a safer place, the threat of jail places the community more at risk (Hollow Water, 1994).

In part because the scope of abuse was so widespread, the Resource Team concluded that the conventional legal system could not adequately address the crisis and the individual and community healing it required (Bushie, 1999).

Members of the CHCH program also found that not only did the legal system, and the threat of incarceration, fail to deter abuse, but the consequences were often increased violence as offenders who returned to the community following imprisonment posed a continued, or heightened risk of harm (Hollow Water, 1994; Sawatsky, 2009). Hollow Water residents cited an overriding lack of trust in the Canadian legal system that prevented residents from cooperating in police investigations when allegations of abuse were reported (Sawatsky, 2009). According to one study of Hollow Water, the founders of the CHCH "saw it as their job to protect the victims and the community, especially the children, from the justice system" (Sawatsky, 2009, p.110). This critique of the effectiveness of the criminal legal system to make communities safer—particularly for communities already targeted by police—is echoed across

the Community Accountability and Transformative Justice Literature (Critical Resistance, et al., 2003).

In a cost-benefit analysis of the first ten years of the CHCH program, Couture, et al. (2001) found a remarkably low recidivism rate among the offenders processed through the program between 1987 and 2001. Of the 91 offenders who were charged with sexual abuse offenses during this period, there were two cases of recidivism (Couture, et al., 2001), a recidivism rate six times lower than the national average rate for sexual abusing (Sawatsky, 2009). Sivell-Ferri's (1997) study of Hollow Water's CHCH process also found that the program was more successful than mainstream interventions in reducing recidivism and implementing sustained accountability. Although CHCH has not yet taken cases of juvenile sexual offenders, one of the key recommendations of the report was for the investment in funding for young sexual offender treatment, given the increasing requests for such treatment (Couture, et al, 2001).

Ross (1996a) reports that the CHCH model may be less effective in cases where the victim is an adult (rather than a child) finding a greater likelihood that, for example, in cases of domestic violence where an adult woman has been victimized, she will be blamed. The Hollow Water model appears to have been most effective in addressing cases of adult physical and sexual abuse of children. Further research is needed into how this and other models ensure the protection of adult and child victims during, and following the conclusion of the Healing Circle process.

Multisystemic Treatment.

While there are currently no empirical studies on transformative justice interventions in treating juvenile sex offenders, other systemic ecological models offer important findings to guide further research. Multisystemic treatment (MST) is one such model which has been more widely studied (Borduin & Schaeffer, 2001; Borduin, et al., 2009; Swenson, Henggeler, Schoenwald, Kaufman, & Randall, 1998). MST integrates clinical techniques from behavioral and cognitive-behavioral therapies and structural family therapy into the identified patient's broader social ecology (e.g., across individual, family, peer, school, and neighborhood domains) and includes members of the youth's family and/or other appropriate members of the youth's social ecology (e.g. teachers, extended family) in conjoint or family therapy. Services are typically provided in home, school, and/or neighborhood settings and youths and their families receive multiple contacts each week (e.g. treatment in one study included approximately 3 hours of intervention each week across family, school, peer, and individual systems) (Borduin, et al., 2009).

Swenson, et al., (1998) found that initial data on the effectiveness of MST in treating adolescent sexual offenders to be promising. Given the multiple factors influencing the etiology of juvenile sexual offenders, the authors argue that a multisystemic approach "that includes the family, victim, and persons within the extrafamilial, school, and community systems may be the most effective route for reducing offender risk and increasing victim and community safety" (Swenson et al., 1998, p. 336). The MST literature is also somewhat unique in recognizing the clinical needs of those connected to the "identified patient" (Borduin & Schaeffer, 2001). While the theoretical basis for MST is distinct from that of Transformative Justice, there are important overlapping features and findings from the MST literature which can inform developing TJ theory and practice. One such finding is the principle within MST which holds that social

relationships within the offender's life offer potential strengths to the treatment process and can be a source of support and accountability (Swenson, et al., 1998). This is consistent with the principles of TJ, which suggest that bystanders are an underutilized resource in holding offenders accountable.

In one of few randomized effectiveness trials evaluating treatment outcomes with JSOs, Letourneau et al. (2009) investigated the relative effectiveness of multisystemic therapy (MST) adapted for JSOs in comparison with the standard treatment for JSOs, referred to as "Treatment as usual for juvenile sexual offenders (TAU-JSO)" which includes cognitive-behavioral based individual and group therapy (Letourneau, et al., 2009). Study participants (*n=127*) were youth aged 11-17 years who had been convicted of a sexual offense. Letourneau et al. (2009) found favorable outcomes in the MST group in reducing the risk of sexual reoffending, a finding consistent with two previous MST efficacy studies with JSOs showing widespread support for holistic and comprehensive interventions with this patient population (Borduin, Henggeler, Blaske, & Stein, 1990; Borduin et al., 2009). Letourneau, et al., (2009) note that this supports a growing consensus in support of multiple ecological and comprehensive interventions for children and youth with serious aggressive, antisocial behavioral problems, including sexual offending.

Application of Transformative Justice to Treatment with JSOs

Although this researcher has not found specific literature (empirical or theoretical) addressing the application of transformative justice/community accountability frameworks in responding to incidents of juvenile sexual offending, the principles of this model have significant potential for responding to this phenomenon. First, TJ/CA frameworks recognize the complexity

of intimate relationships within which sexual abuse most commonly occurs. Rather than addressing sexual abuse as an individual mental health issue, TJ/CA theories offer a framework for addressing potential interpersonal and intergenerational characteristics of abuse prioritizing survivor safety and offender accountability in the process. Second, by emphasizing safety and accountability, rather than retribution or punishment, TJ principles support the creation of conditions in which people experiencing abuse (including people in danger of abusing, people who are abusing, and victims and bystanders) are supported in coming forward to address the harm and the need for healing. Critically, TJ principles place individual healing and responses to individual cases of abuse in the broader social context. TJ challenges the replication of abusive dynamics (such as incarceration), instead seeking responses to harm that support long-term accountability and community capacity-building to prevent and respond to harm. Finally, in contrast to the prevailing model, TJ/CA involves a broader network of people in generating the ideas, strategy, and dedication to the work of transforming conditions of violence and creating long term safety (Creative Interventions, 2012; Ross, 1996b).

CHAPTER SIX

DISCUSSION

In this final chapter, I begin with a case vignette and discuss the case from the perspectives of Relational Theory and Transformative Justice. I then review the ways in which the two theories contribute to understanding the individual and systemic dimensions of juvenile sexual offending. In conclusion I consider the implications of this study for future research and clinical work with this population.

Case Vignette

In a study of Restorative Justice programs in indigenous communities in Canada, Rupert Ross (1996b) describes the case of Carl[20], who at age 15 was being prosecuted (in Canadian court) for sexual abuse he had committed against multiple victims. Ross reports that at the time of his sentencing Carl admitted that he had victimized seven people, including much younger children and one peer. After being sentenced into custody and treatment, Carl acknowledged victimizing an additional six people.

Of Carl's developmental history, we are told that in his first five or six years he was physically and sexually abused by his father and witnessed his father physically and sexually abuse his mother. Ross reports that Carl's father also forced his mother to participate in the sexual abuse that was done to him. Child protective services intervened when it was reported that Carl's older brother was being abused. Carl was then placed to live with his grandparents in another community. During this time (between ages five or six and eight or nine) an older male

[20] The name and identity of this case is disguised according to appropriate ethical and legal protections. The pseudonym "Carl" is used in Ross' (1996b) original discussion of this case.

cousin sexually abused Carl repeatedly. That abuse continued until Carl was himself arrested, at age fifteen.

Discussion of Case Vignette

While there are many unknown elements of this case from the brief case vignette provided, it is illustrative of many central issues in the treatment of juvenile sexual abusers. Consistent with the empirical research on this population, Carl's early development was defined by repeated, severe physical and sexual abuse at the hands of his primary caregivers. As discussed in Chapter Four, profound relational trauma in a child's significant early relationships can severely impact the child's development including the development of a cohesive self, and the capacity to symbolize and integrate affective and relational experience; faculties necessary in organizing inner and outer experiences (Blaustein, et al., 1996). Carl's case is an extreme example of ongoing assault in an essential attachment relationship during a child's earliest developmental stages. Van der Kolk (1989) reports that an earlier age of onset of abuse is correlated with a greater vulnerability to the loss of conscious memory of the trauma and to traumatic repetition phenomena (Van der Kolk, 1989). Similarly, Davies and Frawley (1994) report that without intervening experience, dissociated states, cut off from other cognitive and emotional processes, often emerge in the form of "recurrent intrusive images, violent or symbolic enactments, inexplicable somatic sensations, recurrent nightmares, anxiety reactions, and psychosomatic conditions" (Davies & Frawley, 1994, p. 31). Carl suffered severe, chronic relational trauma at the hands of multiple perpetrators, with whom he had complex emotional and/or dependency needs. Further, that the abuse began at such a young age indicates that Carl never had the opportunity for foundational developmental experiences outside the context of the

abuse. It is likely, then, that Carl was highly vulnerable to the development of dissociative defensive patterns which likely became consolidated over time in the context of repeated trauma and the apparent absence of intervening or supportive relationships. Although we do not know Carl's age when he began victimizing other children, it appears that he was continuously abused by his cousin up until the time that he was taken into custody by the courts. This suggests that Carl never had the opportunity or the environmental support necessary to process any of the trauma he had endured throughout his life. It is plausible, then, that his victimization of other children represented a severe example of dissociative reenactment of his own abuse.

This case raises deeply challenging questions both in terms of individual clinical treatment and the broader social context of his case and treatment. Carl's case highlights the ways in which dissociation and reenactment phenomena may be present in the individual psychological and behavioral dimensions of adolescent sexual abusers who themselves have been sexually abused. This case also illustrates the potential for dissociative reenactment in the systemic response to juvenile sexual offending. The dominant criminal legal paradigm primarily seeks to remove Carl from the public and to punish him for the harm he has caused. In a sense, this represents a collective dissociation, splitting-off the conditions that contributed to Carl's victimization and his victimization of others, and dissociating his experience as a victim from his offending behavior. Out of this dissociative response, Carl is placed in an institution where he may be exposed to further explicit abuse, and/or will be subjected to conditions that mimic the loss of control, routine punishment, and absence of emotional safety characteristic of his original trauma. In this way, the larger systemic response to Carl's complex case represents a parallel process of dissociation and reenactment writ large.

Finally, it is worth noting the intensity of the countertransferential response this case evokes. Even at this remote distance, with no direct contact with the case, reading and attempting to draw larger meaning from Carl's story provokes strong and difficult feelings; a sense of disorienting overwhelm and horror, a sense that this is too violent, too painful to be spoken of, to be written about and discussed here, a desire to disavow the knowledge that such violence could exist, that this happened and continues to happen. From a Relational perspective, this countertransferential response provides information about the fragmenting, dissociative response that is perhaps universally, if differentially, experienced in the face of such complex trauma. It is possible that such difficult countertransferential experiences contribute to the dearth of research or practice with this population among psychodynamic/psychoanalytic practitioners.

Summary of Clinical Implications and Directions for Future Research

The empirical literature on JSO describes a heterogeneous population. While the etiological literature is inconclusive, complex childhood trauma stands out as a common factor among a significant majority of adolescent offenders. This suggests the need to account for the intergenerational and traumatogenic factors that can contribute to adolescent sexual offending. Relational Theory and Transformative Justice offer preliminary, prospective frameworks for understanding and developing treatment responses that account for this complexity in JSO treatment on the individual and systemic levels.

Relational Theory offers a framework for understanding the ways in which trauma, and particularly chronic, severe childhood trauma, fundamentally impacts a child's developing sense of self, and may lead to a highly fragmented, dissociated self-organization. This provides important counter-considerations to the classical psychoanalytic and predominant CBT models.

The treatment model of choice in JSO treatment in the US, CBT maps onto a classical psychoanalytic model that essentially seeks to strengthen superego functioning in response to dangerous libidinous drives. CBT interventions largely target the moral reasoning (similar to psychoanalytic conceptions of the superego) capacities underlying individual cognitive and behavioral patterns. The Relational Theory framework presented here offers a different view of the mind, and of the mechanisms of conscious and unconscious functioning. Emphasizing dissociation, rather than repression, as the pathognomic response to ongoing childhood sexual abuse, Relational Theory suggests that a treatment model primarily seeking to strengthen the superego may actually collude with dissociative tendencies. Treatment aiming to foster feelings of shame, guilt, and remorse for the harm offenders have caused, prior to the integration of dissociative self-experiences, may actually further consolidate the dissociative process.

Through its understanding of dissociative self-states and traumatic reenactment, Relational Theory offers critical insight for understanding the influence of unconscious processes in individual and group or societal behavior. This model suggests that treatment primarily targeting conscious-verbal processing will fail to address the unconscious processes underlying violent and abusive behaviors. This study has underlined the relevance of contemporary psychoanalytic ideas for understanding and treating adolescent sexual offenders. There is a great need, then, to extend the reach of psychoanalytic and psychodynamically-informed research and practice, and to adapt the clinical wisdom of Relational Theory to address the complex intrapsychic and interpersonal challenge required to interrupt the epidemic rates of CSA and work toward long-term reparations.

Transformative Justice offers a macro-level approach to integrating the clinical implications of Relational Theory into a systemic response to JSO and CSA. Transformative

Justice, by centralizing immediate safety and healing as well as long-term transformation of the conditions in which abuse occurs, provides a framework to address the wider context within which abuse happens. Without sacrificing safety, accountability and the need for repair, this model explicitly recognizes something that RT helps to explain; the ways in which unresolved (dissociated) traumatic experiences can be reenacted, sometimes in the form of sexual offending.

The empirical literature reviewed here suggests that young people are more responsive to treatment than older offenders (Veneziano & Veneziano, 2002). The fact that some young people, such as Carl, were being victimized contemporaneously to their own offending behavior, may also support Transformative Justice work with this population; such cases may be more readily supported by community members, as it is more intuitive to maintain the humanity of the offender and to recognize some of the larger social conditions interconnected with the individual case.

Transformative Justice frameworks importantly, provide analysis for the ways in which the current system perpetuates a collective dissociative response to the epidemic of CSA. Transformative Justice thinkers have articulated the ways in which intersecting systems of oppression—including racism, heteropatriarchy, ableism, gender and age oppression—both contribute to and are reinforced by intimate violence (Kershnar, et al., 2007). The empirical data reviewed in this study demonstrate that the current system is only addressing a small fraction of actual incidents of CSA (Abbey, 2005; Borduin, et al., 2009; Caldwell, 2007). Moreover, it appears from the preliminary study of the available data examined here, that of the small percentage of cases of JSO which are adjudicated, young people of color are disproportionately criminalized. This indicates that, consistent with TJ analysis, institutionalized racism contributes to the dissociative collective response to juvenile sexual offending, disproportionately enforcing

legal punishment for a small few, and collectively ignoring the vast majority of cases of JSO. The idea that prisons will provide safety is actually a cause and effect of the racism that contributes to this collective dissociative response.

Transformative Justice, Restorative Justice and community accountability programs currently being piloted outside of the mainstream mental health and criminal legal system offer a potential intervention to transform, rather than replicate, these dissociative processes in the face of severe trauma. Berma Bushie, one of the founders of the Hollow Water Holistic Community Healing Circle, argues that interventions into CSA can be strengthened when mental health workers and the broader community work together. Bushie advocates for new negotiated relationships across groups who have a stake in addressing child sexual abuse including Child Protection workers, members of the legal system, mental health workers and, in individual cases, the victim, and victim's family, the victimizer and the victimizer's family as well as other community members and community agencies affected by the abuse (Bushie, 1999). Similarly, the community accountability organization Creative Interventions

> assumes that the relationships, families and communities in which violence occurs are also the very locations for long-term change and transformation. It assumes that those most impacted by violence are the most motivated to challenge violence. It assumes that friends, family, and community know most intimately the conditions that lead to violence as well as the values and strengths which can lead to its transformation (Creative Interventions, 2012).

Both Bushie and Creative Interventions demonstrate ways in which TJ/CA offers a framework to include a greater network of people than the mainstream model and to harness this knowledge and capacity to challenge interpersonal violence.

This study has sought to explore an emerging area of grassroots theory and practice and a clinical theory which, as of yet, has not been studied in relationship to this population. For these reasons, and due to the limited scope of this project, this study may raise more questions than

offer definitive answers. With that in mind, this study points to important areas for future research. As this study has raised questions about the possible role of institutional racism in influencing who is criminalized for JSO, further research is needed into the potential relationship between racial identity and the adjudication of sexual offending. Relatedly, further research is needed into what, if any, treatment, or response of any kind, is provided in cases of JSO that are not adjudicated in the courts.

Transformative Justice, in recognizing the importance of the wider social conditions surrounding individual incidents of intimate violence, raises the issue of the under-examined role of bystanders to CSA (Hirschfield-White, 2010). This raises critical questions for further research including the following: Is there a correlation between bystander (non)responsiveness and a history of trauma among bystanders? And, does a prior trauma history among bystanders contribute to a dissociative response upon witnessing or disclosure of abuse? The potential to better account for the role of bystanders represents a significant under-examined area for improving theory and practice in addressing interpersonal trauma. Clinical research is also needed into the possible application of Relational Theory in working with children and adolescents and specifically in treating patients with traumatogenic dissociative phenomena and violent/abusive behaviors.

The Relational Theory and Transformative Justice literature poses significant challenges to the field of social work and to broader communities of people concerned with finding meaningful strategies to intervene in and prevent intimate violence. Working with a young person who has been both a victim and a victimizer raises profoundly challenging clinical and societal questions. This work challenges us, as clinicians, and members of larger social communities, to develop a greater capacity to tolerate and meaningfully respond to a highly

uncomfortable degree of contradiction, dissonance and complexity. This is, however, a challenge that may be necessary to develop effective individual and collective interventions into the intergenerational trauma of CSA.

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