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SEXUAL RISK ASSESSMENT REPORT

Member's Name : Michael Kula Date of Birth:9/18/2000

Male _X__ Female ____

MassHealth Date of Referral: 8/25/2016

DCF Area Office: Lowell

Describe concerning sexual behavior and history briefly:

Michael Kula is a sixteen-year-old adolescent who was referred for a sexual risk evaluation by his DCF caseworker, to determine his clinical needs and to make placement recommendations given extensive difficulties while living with his aunt with inhibiting sexualized behaviors, which possibly could put younger children in the home at risk. It was noted in the DCF referral that Michael had previously been placed at a CBAT program at Brandon Residential Treatment Center in May given concerns about his extensive viewing of pornography (including incest and sibling sexual abuse sites), leaving pornographic sites open on shared devices in the home, as well as engaging in compulsive levels of masturbation while a younger male cousin was in the room. It was also reported that Michael had stolen underwear from his twelve-year-old female cousin for unknown reasons and would attempt to sneak into her room at night. Michael has also videotaped himself masturbating on many occasions and it was unclear what he intended to do with these videotapes. After a review of his difficulties by clinical staff at Brandon Michael was discharged home along with a developed safety plan and clinical supports coordinated by Wayside Youth and Family Services. As these supports were being put into place and the safety plan initiated Michael continued to have difficulties with breaking safety rules, reported feeling depressed and overwhelmed and downloaded hundreds of pornographic images to a phone that he obtained in violation of his safety plan. Given the intensity of these images, the compulsive nature of his viewing these images and continued concern about his inability to maintain healthy boundaries in the home he was admitted to Arbour Hospital in Attleboro and then back to the CBAT program at Brandon. Since his return to Brandon Michael has had some difficulty in his

interactions with peers but presented as open to help with his problems which he doesn't believe he can change on his own. It was noted that just before the evaluation was to begin that additional concerns were being raised that Michael may have engaged in inappropriate sexualized behaviors with girls who used to visit the home and who were related to his aunt's husband. This information was somewhat vague and still being investigated.

Prior to his current placement Michael lived in Dracut with his maternal aunt, her husband, as well as their three children (age 12, 8, and 3) His aunt's husband Jared has two daughters who previously would visit the home on weekends although these visits have currently stopped. According to family treatment providers Michael's inappropriate sexual behaviors have caused a great deal of stress in the family and his caretakers are very concerned about the safety and well being of the other children in the home given Michael's difficulties responding to limits in the home. It should be noted that despite Michael's reported attempts to stop inappropriate sexual behaviors he continued to act out impulsive sexual drives despite high levels of supervision and awareness that this behavior broke rules in the home. The extent and frequency of these incidents especially under close supervision seemed to indicate a fairly high level of impulsivity and apparent compulsion. It was reported that his aunt and uncle did not feel that they were equipped to provide sufficient supervision while safe guarding the other children in the home from being exposed to pornography, masturbation or possible sexual abuse.

At the time of the evaluation Michael had been placed at the CBAT program at Brandon Residential Treatment Center in Natick for the second time and he remained in this setting during the course of the risk assessment. The request for the risk evaluation was to help determine the level of care that he required and appropriate course of treatment given the severity of his past concerning behaviors in the home, and reported emotional agitation that led to his psychiatric hospitalization at the Arbour Hospital and previous placement at Brandon.

Michael was informed in his first session that the purposes of the risk evaluation was to help his DCF worker determine his clinical needs given his alleged history of inappropriate sexualized behaviors, and disregard for rules and limits in the home. He was told that the assessment would not be confidential, as it was necessary to share this information with DCF to ensure his own and other's safety. When he was told that he could refuse to answer any question about any inappropriate behaviors in the home Michael replied that he would answer any question, as he wanted to show that he was serious about changing and wanted to show that he was safe to visit this home. Michael currently does not believe he should be living in the home and he hoped I could help find him a place to live where he could get help with his problems.

Past Behavioral Difficulties

According to his caretakers Michael has had a history of behavioral difficulties from a young age, which seemed connected to cognitive difficulties and developmental delays, which manifested in his difficulty with attention, impulsivity and distractibility. When others have tried to help him he reportedly has been mistrustful of others, showed difficulty in communication, was fairly introverted and had difficulty remembering skills that he was taught at a younger age. Michael's aunt noted Michael's problems became more apparent when he started school but his grandmother was resistant to getting him help. In second grade it was apparent that other children were bullying him and he was unsure how to appropriately respond to this harassment

and would use a stuffed animal to self soothe up to age twelve. Michael was also described by his aunt as being somewhat rigid, secretive, easily agitated, insecure, isolated and having difficulty with emotional stability for much of his childhood. At age twelve he was sent to live for the summer with another aunt and it was surmised that this was where he was first exposed to porn by going on his aunt's IPad. When confronted about this behavior he typically would shrug and not give a verbal response. There was also concern that Michael continued to have difficulty relating with peers his age and it was noted that Michael was much more comfortable relating to children much younger than himself. In 2014 he began to talk about wanting to hurt himself and he became "obsessed" with guns. He was placed for partial hospitalization at the Lowell Treatment Center and was referred for ongoing treatment to The Center for Family Development in Lowell. According to Michael's aunt Michael attended therapy for several sessions and she was informed by his therapist that his behaviors seemed typical for a boy his age and therapy was discontinued. Soon after discontinuing therapy Michael began to show more pronounced difficulties with stealing, lying, and going on library computers to view pornography. At that point Michelle and Jared became more concerned and begin to warn him about the legal ramifications of viewing and sending pornography. Despite this warning Michael seemed to become more obsessed with sexually charged material and would take magazine pictures into the shower for the purpose of masturbating to these images.

In reviewing with Michael his perception of his own behavioral difficulties he was able to admit to several problems but tended to minimize their importance and impact on others. It was difficult to assess from his interviews if he was minimizing problems to not have to think about them or he honestly did not know why they were a problem. Michael described his principal difficulty as managing agitated responses to frustration or feeling that others don't like him and there being little or nothing he could do about it. Michael reports that he often does things randomly and he was unclear why he acts the way he does. He saw himself as oppositional to requests, that he would frequently lie to avoid consequences and that he often could not use skills he was taught to help him with his problems. He described himself as mean although not physically and while he might threaten to hurt a younger child ("I'm going to beat your head in") if they bothered him he typically would not follow through with this threat. He reported that while he doesn't purposely destroy property he has broken things "accidentally" when he would get upset and he reported a fascination with lighters although he has never started a fire with one.

Michael noted that he often is depressed and that is why he does not want to do what he is supposed to do. He added that he has often struggled with household rules leading to emotional agitation and being hospitalized due to suicidal ideation. When listing his problems Michael noted that he, is addicted to pornography, has bad friends, has trouble making friend, often is depressed, has difficulty telling the truth and often can not talk to people because he is too shy. Michael added that peers are often mean to him and recently someone at his school tried to choke him and no one tried to help him. Michael reported that he had one male peer friend named T. but that he was a bad influence as he often told him to leave the home after curfew, encouraged him to look at underage pornography, dared him to do illegal things like stealing, told him he should carry a knife and undermined any attempt he made at stopping viewing pornography. While this boy seemed to encourage Michael's negative behaviors Michael admitted that even when he was not around his behaviors often were impulsive, fairly repetitive, and disconnected from how these behaviors would impact on others. A review of collateral

impressions of Michael confirmed that he is often disconnected from the thoughts and feelings of others and he seemed unaware how his behaviors affected others. This lack of awareness seemed less conduct disordered and more a reflection of confusion around how others think and feel.

Briefly Describe Victimization History

In regard to Neglect-Physical -Sexual Abuse

According to DCF records Michael is currently under the guardianship of his maternal aunt, Michelle Kula although he was previously under the care of his grandmother with whom he lived since he was a baby. Michael was cared for by extended family due to the death of both of his parents. According to DCF records there were no reports of abuse of Michael although there were concerns about neglect, which led to guardianship being shifted from his grandmother to his aunt. Michelle noted that Michael should have had more intensive services from a younger age but because of her mother's resistance to recommendations these services were never requested. Michael reported feeling supported by his aunt and uncle but that he probably should not live with them because they live on a farm and he did not want to take care of animals and he often was getting into trouble because he could not stop certain behaviors. In terms of abuse outside of the family Michael stated that older boys often physically abused him in his school and community while others would call him names, hit him and make him do things as a form of harassment.

When he would think of all the mean things that happened to him growing up Michael reported feeling angry, worthless, powerless, picked on, unloved, afraid, unwanted and frustrated. Michael added that over time he gradually has become more and more depressed and currently; he dislikes most people, he doesn't want to get close to others, and thinks that others are out to get him. As a way of coping with agitated feelings Michael will write out revenge fantasy's in a notebook outlining what he would like to do to others if he could and sharing thoughts of despair and destruction that his hero's act out in the world. Michael added that others shouldn't worry about these writings as he is just trying to write up a script to a horror story or to a song about a boy who has been treated badly in the past. He can relate to "this boy" who often feels; afraid, no good, uncomfortable, confused, different from other kids, embarrassed, and angry. Michael thought that as a result of growing up in a bad family "this boy" holds his feelings in, he gets upset easily, he has trouble concentrating, he frequently daydreams, often thinks about sex, he does not trust others, he has become very good at blocking out things that he does not want to think about and denying things that he has done.

As part of the current assessment Michael completed the **Childhood Trauma Assessment** scale and his responses show a high level of traumatic response to life events that include nightmares, pretending to be someone else, feeling lonely, masturbating too much (numbing himself), thinking about sex when he doesn't want to (intrusion of sexual thoughts and feelings), struggling with others, feeling scared of women, forgetting things, getting easily upset, feeling he did something wrong, trying to not have any feelings, getting upset when others talk about sex, and wishing that bad things never happened to him. Michael also reported compulsive thoughts and feelings in regard to sexual acts, wanting to engage in sexual acts to see what it felt like and getting upset with others when they wanted to talk about sex. The number and frequency of his

responses indicated a high level of traumatic reactivity to limited reports of abuse and little awareness of coping skills to deal with agitated traumatic responses. His responses seemed to indicate that Michael is preoccupied by conflict and tension connected to feelings of victimization by others and a developed fantasy response that seems to block him from learning appropriate and healthy responses.

Describe Briefly Home Situation

Michelle and Jared and their three children currently live on a farm in Dracut. Michael shares a room with a nine-year-old male cousin and over the past year he has made little attempt to refrain from openly masturbating in the room while his cousin is there. Michael up to this point has helped with the care of animals on the farm and he reports hating to care for turkeys and other birds. Michael hoped that he would not have to return to live with Michelle and Jared as he no longer wants to participate in the upkeep of the farm and he often has to struggle with everyone in the home when he does something wrong. Michelle and Jared noted that Michael has been a hard child to parent and that he considerably adds to the stress in the home when he is there. There also was concern about his sexualizing his nine-year-old cousin and possibly acting out impulsive sexualized behaviors with a much younger three year old in the home. Michelle and Jared do not currently feel that Michael can be managed in their home and they worry about the safety of all the younger children in the home given his lack of response to previous interventions.

Comments On Therapeutic Issues:

Michael is an adolescent with a history of behavioral difficulties, resistance to direction, a traumatic past and a family history of emotional difficulties and stress. Michael struggles with distractibility, impulsivity, anxiety and ongoing depression. Michael was referred for a Neuropsychological evaluation with Seth Doolin Psy.D in 2014 due to concerns around developmental delays and to rule out a possible diagnosis of being on the Autism spectrum. Michael showed inconsistent abilities on many domains of cognitive functioning, which reflected borderline abilities. His full scale IQ was 76 with his greatest weakness in Executive Functioning and evidence of depression and extreme feelings of vulnerability in his Emotional Functioning. The conclusion of the assessment was that Michael did not present with an Autistic Spectrum Disorder or with Development Delay but was seen as showing signs of a mild neurocognitive disorder causing impairment in overall cognitive functioning. It was recommended that Michael needed to begin individual therapy as soon as possible to help him learn coping skills and to help his family learn signs of suicidal ideation, which it was predicted, might grow over time. This evaluation also noted his vulnerability to bullying in the school and suggested that supports be developed to help Michael in this setting.

Michael was referred and started to attend therapeutic services in Lowell in 2014 but his therapist reported to his aunt that Michael seemed to present "like a typical adolescent" and he was only seen for a short period of time before therapy was discontinued. His aunt and uncle realized over time that Michael still needed treatment and they hoped that any future treatment can help him manage agitated feelings, help him understand his driven sexualized behaviors and help him learn ways of forming healthy connections with others.

IEP testing conducted at Lowell Technical High School in 2016 identified several issues of

concern in Michael's functioning. It was reported in the emotional functioning component that Michael has difficulty understanding social cues within his peer group. He also has trouble problem solving, which negatively impacts peer relationships, and he would over share intimate material in the classroom. He was referred for counseling in the school setting although there was not a high level of concern about his ability to contain inappropriate behaviors in this setting.

In a review of his therapeutic needs at the start of the risk evaluation he showed a difficulty with understanding and forming healthy relationships, understanding options in his responses to stress, feeling disconnected from others, showing high levels of emotional reactivity, and a dysfunctional response to sexual arousal that manifests in compulsive masturbation, driven viewing of pornography and difficulty managing boundaries.

Given his responses during the risk evaluation Michael's clinical treatment needs include:

Disturbed Sexual Arousal:
Disturbed arousal indicates arousal to thinking and acting out behaviors that violate other's rights and boundaries. This arousal is assessed through self reports and reports of others who are caretakers. It was reported that Michael has an extensive history of viewing pornography in a driven manner and a history of masturbation, which seemed excessive to his caretakers and is resistant to interventions. In addition Michael was seen by his caretakers as limited in his ability to form relationships and is highly vulnerable to the manipulation of others which might make him a victim of sexual exploitation. Michael presented in this assessment as cooperative although he was somewhat confused by some aspects of the evaluation which he was willing to answer if they were reframed for him. Michael had manageable difficulty talking about his sexual history and he became only slightly more constricted when relating his perceptions of sexual thoughts and feelings.

In reviewing his sexual history Michael reported learning about sexuality at age twelve when he first saw a sexual scene on a TV movie. Soon after that he was able to access pornographic images on an IPad and by age thirteen he was masturbating to pornographic images about three times a week. He remembered that he must have made some mistakes about how he masturbated in the home as his aunt and uncle told him that he needed to be private when he would masturbate and that the best place to do that would be in the bathroom. Michael believed that he was able to manage sexual thoughts and feelings fairly well up to age fifteen at which point he felt that his life was miserable, he had no friends and everyone told him how ugly he was. At that point he started to look at transsexual images on various devices and thought that his life would be much easier if he could transition to female. Michael felt that the outcome of being transsexual would lead to his being liked by others, he could start over fresh as a new person, he would be much more attractive and he could be accepted. At that point he began to steal underwear from his younger cousin to wear and to see if he liked what it felt like. This rationale for stealing underwear seemed somewhat inconsistent as he continued to steal underwear after he decided that he no longer wanted to be transsexual and the motivation seemed to shift to be a form of stimulation for the purposes of masturbation. At approximately the same time he met a peer age male in his neighborhood named T. and this boy encouraged him to engage in all sorts of behavior that he had not thought of previously. Also at this time his uncle's daughters who

previously would visit the home stopped coming on visits as their mother thought Michael was sexually harassing them, although he denied this.

Through age sixteen Michael would watch pornography with T. who reportedly exposed him to underage pornography, violent pornography, lesbian sex, and Japanese anime. At that point he began to masturbate in a much more intense level, he was indifferent to how this might impact his younger cousin who was in same room, and he started to have strange thoughts about sex that he didn't want to share. Michael saw T. as a "father figure" who went out of his way to spend time with him and that he would do anything T. suggested even if it caused him pain or he knew it was illegal. He would sneak out of the house at night, he would steal objects for T. and he would let T. slap him as T. was working on a video about "hitting people in the face." Michael denied being sexual with T. but thought at one point that they masturbated in the same room.

At various points Michael tried to stop watching pornography about older men and younger girls but reportedly T. would hold up an image of a younger girl and say, "check this out" which led to his masturbating at an even higher frequency than before. When his aunt and uncle finally realized the extent of his pornographic use they tried to help him stop by telling him that he could go to jail and by assigning him physical tasks as punishment. When this had little impact he was placed at Brandon in May and when he was discharged a safety plan was put in place, which limited his access to pornography. Soon after he returned home he bought a phone without his aunt and uncle's knowledge and began to download extensive amounts of pornography from Anime sites, from chat lines, and began to take videos of himself masturbating. When he was asked why he downloaded over forty videos of himself masturbating in various settings and in two with the family dog's head in close proximity to his genitals Michael was unsure stating, "I do lot of random things." It was unclear from these videos if Michael was attempting to be sexual with the family dog and Michael denied that he would ever do this. Michael also denied ever dating anyone up to this point although he reported that he had a girlfriend at the Arbour Hospital. When asked what made her his girlfriend in a highly supervised unit Michael reported that she told him he was cute.

Michael presented with agitated confusion about his thoughts and feelings around compulsive viewing of pornography, videotaping himself masturbating, viewing hundreds of pictures of girls when they were in a state of undress from Google and difficulty with understanding boundaries around sexualized behaviors and he showed little awareness of how these behaviors may have affected others.

Michael's responses to **the Child Sexual Behavior** questionnaire which assesses attitudes towards sexual issues indicated that Michael currently thinks about sex a great deal, that he felt more excited about his sexual thoughts and feelings than he should, that he sometimes wants to do sexual things without thinking of others or worrying about what will happen after, that he is unsure what he should do when he has sexual thoughts and feelings and he is concerned that others might think that he has a major sexual problem based on past behaviors. His responses to the **Wilson Sex Fantasy Questionnaire** indicated thoughts about sexual behaviors, which were fairly immature and reflected a developed fantasy experience consistent with an individual who isolates from others or does not feel competent in the world. His responses to various scenarios indicated high levels of arousal in regard to multiple partners, forcing others to be sexual,

seducing an "innocent child", looking at a high volume of pornography, being preoccupied by sexual thoughts and feeling, and having sex with someone much older than he is currently. Michael's answers on the **Bumby Cognitive Distortions Scale** which measures values and attitudes around the issue of rape indicated a limited awareness of others rights and a belief that sometimes you have to convince others to be sexual. In general his current clinical presentation indicates poor ability to inhibit arousal and poor social judgment in making decisions about sex.

Self Monitoring and Social Skills:
When describing his feelings and behaviors Michael tended to only sporadically know when he is having difficulty and was somewhat uncomfortable admitting to problematic behaviors. He exhibited a lack of mature social skills, had fairly limited understanding of abstract concepts and tended to relate in an impulsive manner in his interactions with others. He was unsure how he should relate to others during stressful events and was especially unsure how to maintain or repair relationships. Michael reported that he had few if any friends and he reported being worried about his ability to pick healthy people to be around.

Communication Skills:
Michael shows limited abilities in expressing his thoughts and feelings when he is stressed and typically will avoid or regress into fantasy play when confronted. Michael showed difficulty-processing information that involved others concerns and worries, as it was difficult for him to take responsibility for his behaviors and see other's point of view. Michael can talk to sympathetic adults about difficult or stressful subjects but will wait for others to bring up difficult material.

Cycle Behaviors:
Michael currently has difficulty predicting events and is unclear what he was thinking or feeling prior to an event. He reports, "I often do things randomly." He therefore does not seem to be a good candidate for cognitive therapy to learn and understand alternative ways to manage negative thoughts and behaviors.

Anger Management:
Michael historically has a history of agitated response to stress that manifests itself through impulsive, angry behaviors or withdrawal, during which he thinks of ways he can get back at those that have hurt him although this typical remains in a fantasy realm. While Michael remembers being taught some skills on how to calm down when he is upset, he often will not be able to use these skills and he will become depressed. Michael also has shown fairly primitive responses to stress and anger by being oppositional, threatening to hurt himself and becoming silent. Michael reported that his anger is typically triggered by feelings of powerlessness, and being taunted by others. Michael reported that he does not like to be victimized by others and that his anger helps him think of ways to avoid problems in the future. Michael's answers to the **Buss-Durkee Hostility Inventory** indicated a moderate level of anger and hostility towards others although he sometimes has difficulty listening to others. Michael has a depressive-agitated style, which is fueled by his lack of understanding of why others act the way they do and which can lead to emotional struggles with others.

Victim Empathy Skills:
Michael showed limited abilities to be empathetic towards others and he showed little sensitivity about how his behaviors might affect others. Currently his level of empathy is not sufficient to stop him from acting on abusive impulses.

Clinical Formulation (Comment on youth's ability to admit the problem; accept the treatment interventions; and the youth's ability to safely reside in a community placement with other children):

Michael is a sixteen-year-old adolescent who was referred for a risk evaluation by his DCF caseworker to determine his clinical and placement needs given allegations of inappropriate boundary violations in regard to excessive masturbation and obsessive viewing of pornography, which has led to poor decision making . Michael was fairly easy to talk to during the evaluation although his capacity to think and talk does get influenced by his lack of experience sharing difficult material. While he repeatedly stated that he understood that others needed to determine if he needed help with his sexual issues he was fairly clear that he did need help and that he was open to being placed in a program where he could learn how to inhibit invasive thoughts and feelings. He also was aware that his sexual behaviors were a problem for his family and that he needed to show some improvement so he could be trusted again.

Given Michael's history of impulsive and agitated behaviors as reported in this evaluation a review of the following abilities would be helpful in assessing risk:

Impulse Control:
Michael has a history of impulsive and agitated response to stress and towards those that he feels are treating him unfairly. His behavior in the evaluation was somewhat impulsive and he needed some reminders about the purpose of the evaluation, as he frequently became tangential and somewhat agitated when thinking of his past and current difficulties. Michael's answers on the **Monroe Episodic Dyscontrol Scale** indicated loose control over impulsive feelings, and a limited awareness of alternatives to acting out frustration and sadness. Michael has a history of agitated response to others and he reported that he frequently will act out negative behaviors which typically were more depressive than mean without thinking of the consoquences. Currently his difficulty with impulse control should be seen as fairly high as he tends to be threatening about wanting to hurt himself when stressed and he requires a high level of supervision in response.

Sexual Impulses:
Michael has acted out sexual impulses over an extended period of time as reported by his aunt and uncle and Michael was able to admit to these reports although he minimized his responsibility saying "that a lot of boys do the same thing" although he could see it as excessive. Michael reported that he was pressured to view pornography by his friend T. and that when he has attempted to stop viewing pornography T. would encourage him to start again. While Michael would inconsistently blame T. for some of his problems he could admit that he would act out impulsive sexual behaviors even when T. was not around.

Michael reported that he sometimes felt suicidal about his incapacity to stop himself from

viewing sexual material and which he reported made others concerned about him. Michael's description of his sexual behaviors indicates a fairly high level of impulsivity, which appeared to become compulsive over time. His responses to various assessment scales indicated that he is unsure what constitutes healthy sexual behaviors so he is unclear how to make a choice about when sexual action is appropriate. In reviewing the concepts of safety issues concerning younger children it is clear that Michael currently cannot be trusted around younger children unsupervised although his responses on several assessment scales indicate that he can be appropriately managed when he is with a competent adult to help him with his issues.

There are presently no empirically validated, actuarial instruments that can be used to accurately estimate the risk of adolescent sexual reoffending. Based on the best available research data and consensus in professional clinical opinion, however, a number of high-risk factors have been identified in the literature. The Estimate of Risk of Adolescent Sexual Offense Recidivism (The ERASOR ; Worling & Curwen, 2001) summarizes the available research and expert clinical opinion and this instrument was used to estimate the risk of sexual risk for this client.

At the present time, Michael presents a moderate degree of risk of engaging in inappropriate sexual behaviors as the following risk factors were identified: sexual interest in younger children, preoccupation with sexual thoughts, attitudes supportive of sexual offending (i.e., that children will not be "harmed" by sexual interactions with a teen), a lack of healthy peer relationships, poor self regulation, problematic parent-child relationship, and incomplete treatment for concerning sexual behaviors.

Emotional Stability:
Emotional stability is an important consideration in terms of predicting children who repeat abusive behaviors. Michael is aware that he sometimes has difficulty managing his frustration with others and he is extremely sensitive to how others treat him in his environment. Michael can easily become disconnected from others and tends to blame others for his problems. His perception of emotionally laden interactions may become faulty in highly charged situations, which may lead him to display inappropriate reactions, which may alienate others. He has difficulty forming close relationships with others and he often feels distant and alienated from others. He showed in his responses that he has few effective coping resources to negotiate stress and adolescents with this constellation of attributes tend to show little flexibility in their responses, use avoidance to deal with stress, and if they cannot avoid problems they easily become overwhelmed. His responses to the **Children's Depression Inventory** indicated an elevated number of depressive symptoms. In addition he shows elevated levels of negative mood and self-esteem indicating feelings of being unloved. He scored significantly on difficulty with interpersonal problems and feeling an overall feeling of loneliness.

As part of the current evaluation Michael participated in the **Jesness Inventory–Revised (JI–R)** which was designed to help caseworkers, psychologists, teachers, youth counselors, and parole and probation staff better understand the nature and differences that define the groups of people with whom they work. Michael presented with elevated scores for:

Autism (Au) T-score = 62
Individuals scoring high on the Au scale tend to have their thinking unduly regulated by personal needs are absorbed in self-centered, subjective mental activity. Michael's T-score was slightly elevated on the Autism scale.

Asocial Index (AI) T-score = 63
The Asocial Index refers to a generalized predisposition to resolve problems of social and personal adjustment in ways ordinarily regarded as showing disregard for social customs and rules. The Asocial Index and the Social Maladjustment scale are the best measures of delinquency and adult criminal proneness. Michael's score was high on the Asocial Index, indicating a potential for antisocial behavior. However, the Social Maladjustment scale was not significantly elevated, suggesting that Michael has an awareness of prosocial mores and values, but may be inclined to ignore them.

Withdrawal-depression (Wd) T-score =78
Withdrawal-depression measures a tendency to isolate one's self from others and a perceived lack of satisfaction with self and others. Michael's T-score was greater than or equal to 65 indicating the presence of feelings of depression and a tendency to withdraw. Individuals with high scores on this scale often feel unhappy, sad, lonely, and misunderstood. They are prone to deal with lack of satisfaction with self and others by passive escape or isolation. They also tend to have a negative view of others.

Michael's overall personality profile was classified as **NX Introspective (Neurotic, Anxious)** Individuals of this subtype have internalized a "bad me" self-image. However, rather than acting out these conflicts or presenting a facade of self-sufficiency, the conflict is more often manifested in chronic anxiety and feelings of inadequacy. Even so, the introspective individuals' self-description may, on the surface, be one of actual or potential worthiness and investigation of past causes for present problems is generally valuable. Introspective individuals also show a greater desire to establish friendship with both adults and peers. They search for understanding persons who can respect them. Introspective individuals expect a parent/child rather than equal relationship with adults. They are willing to accept parental or adult guidance as it may earn them the approval and personal acceptance they seek. Many are able to criticize themselves for their failings and to show some awareness of the relationship between the self-critical feelings and the more primitive "bad me" perception of themselves. The majority of youths in this group will be seen as conforming and introverted. At the extreme, however, they will be seen as confused, dependent, and complaining.

The following were found to be characteristic of this subtype within delinquent samples:
They have the highest scale on Social Anxiety and lowest on Alienation. Awareness of feelings of anxiety; deny hostility toward or distrust of adults/authority. Many appear depressed, neurotic, and/or in need of psychological services.

Background: There are typically more out-of-home placements than other types; there is an above average history of running away; and parents are often rated as having psychological problems.

School/Achievement: Generally positive about teachers and school; average in achievement.

Perception of Family: Michael tends to see parents as somewhat withholding and unsupportive; home sometimes has been conflictual, mixed up, unhappy. There tends to be tendency among males is for poor rapport with their fathers (or substitutes).

Self-Concept: Less delinquently-oriented than most other types; prone to be shy, nervous and lacking confidence; do not feel well liked; low morale, usually blame themselves for trouble.

Authority: Generally positive, want approval; tend to prefer strict rules, clear limits, and orderliness in their environment.

Interpersonal: Somewhat easily perturbed; tend to be dependent; more often victims than victimizers; not "cool" or hostile, but may think about running (and do so) under peer pressure.

Recommendations:

The conclusion of the risk evaluation is that Michael presents as an easily agitated adolescent whose low self-concept, sexual preoccupation, over reactivity to stress and depressed mood makes it hard for him to maintain healthy boundaries with younger children and immature peer age girls especially in close proximity. He continues to exhibit a complicated pattern of behavioral and emotional symptoms that are consistent with an adolescent with cognitive difficulties and who are lacking in psychological skills. Michael's history, emotional functioning, current developmental issues, and being in his current environment appear to have heightened feelings of agitated arousal and made him vulnerable to bullying by others and being unclear how to respond to stress. Michael appears to have acted out behavior, which appears disinhibited and fairly driven and it is quite likely that he would continue to act out this behavior in a more direct sexual manner if he returned to a home environment. While he reported that he has not engaged in overt sexual overtures with others he seemed to understand that his behavior would seem strange and disturbed to others and he realizes he needs help to prevent him from acting out sexual behaviors that he would later regret.

Given his clinical profile Michael should be seen as needing direct supervision in his living environment consistent with at least a group home level of care. While Michael has engaged in concerning sexual behaviors indicating a preoccupation with sexual thoughts and feeling he has not engaged in abusive behaviors in the community or in his school setting which argues against his need for residential level of care. Michael should be seen as appropriate for a community school placement although clinical staff should be alerted to his risk issues so they can provide supports in the school setting. While Michael has engaged in some treatment in the past he has not had treatment to address impulsive sexual feelings and focus should be on finding an outpatient therapist with experience treating adolescents fitting Michael's clinical profile. It is possible that Michael could still be supported in the Wayside Continuum Care model, which would address supportive family therapy, specialized individual therapy, and working towards the goal of return home. This model would be crucial in addition to a group home program such as Brandon provides. Currently Michael now seems ready to address several of his issues that place him at risk in a home setting and he now seems more able to constructively use treatment outlined in the above assessment. Clinical intervention should be concrete and treatment workbooks should be used that require Michael to fill out

assignments, which he can keep in a treatment notebook that reflect an understanding of supports, and healthy decision making.

Family treatment should include meetings with his caretakers when his therapist determines this is appropriate to review if it is possible for him to return to their home and if so what would need to be accomplished for this to happen. His family should also be educated about his clinical issues and ways that he can graduate to a less restrictive level of supervision to a home setting. At this point it was unclear from Michael if he can tolerate living long term with his family and this should be reviewed in family counseling as well as looking at possible alternatives if this living arrangement is too stressful for all concerned.

Experience indicates that with certain types of clients, some approaches to intervention or counseling are more effective than others. Decisions about treatment, however, should be made only after careful consideration of each individual case.

NX (Introspective or Neurotic, Anxious) individuals are quite willing to relate to counselors. At times, they are demanding of attention, acceptance, and understanding. They are inclined to be overly dependent. Fights and other forms of aggression are rare. NXs are usually congenial and can develop close relationships. NXs display conspicuous feelings of inadequacy, lack of self-confidence, and dread making fools of themselves. Most of these clients will approach counseling sessions seriously and often attempt to help others work on their problems. Counselors should be tolerant, patient, and willing to discuss problems of a quite personal nature. Most NXs prefer a structured, orderly environment, and a loosely structured environment should be encouraged only when the anxiety generated can be used constructively. Counselors should help them find better, more mature ways of coping with anxiety other than the frequently seen withdrawing, escaping, falling apart, crying, etc. A desirable goal is to increase the client's self-respect. The client should be encouraged to stand up for him- or herself and become more assertive. NXs who become more aware of, and are able to express, feelings of anger are usually more successful after therapy. NXs need a greater awareness of their actual strengths and limitations, needs, and impulses. They need to develop their own perceptions of who they are and what they want to be, in contrast to perceptions that they may have accepted from others.

Individual or "insight-oriented" counseling is regarded as the primary treatment technique. Many NXs have insecurities (often involving sex) and "hang-ups" that need to be explored through individual counseling. They are characteristically motivated to change but feel helpless to do so. It is also important to work through family problems because the NX's insecurities often stem from the family situation. Sometimes NXs expect too much from their parents or from others and need to learn to take care of their own needs. Often, the counselor will be required to deal with the client's feelings of rejection.

In school, NXs are usually diligent, but tend to give up when learning is not immediate. They are often as anxious in the educational environment as they are outside of school. To enhance educational achievement, the teacher should attempt to enhance the NX's self-esteem. To generate motivation, involve the NXs in planning and making decisions about their course of study

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