Pine Grove

Forrest Health℠

Child and Adolescent Sexuality

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Resources (in lieu of handouts)

- www.atsa.com
- www.csom.org
- www.ps-sp.gc.ca/res/index-en.asp#_cor
  - Click on summaries, reports, etc.
  - Contains links to risk assessment tools
- www.mhcp-research.com/ragpage.htm
- www.ncsby.org
- www.neari.com/newsletter
- APSAC

“All development is organization and All organization a development” (Piaget)

- Sleeping together
- Holding
- Cuddling
- Stroking
- Suckling
- Feeding
- Sniffing
- Licking
- Kissing
- Belly kissing
- Blowing
- Bathing
- Drying
- Rubbing
- Rocking
- Looking at
- Caressing
- Touching
- Holding
- Soothing
- Patting
- Joking
- Giggling
- Teasing
- Tickling
- Talking to
- Singing to
- Dressing

ELEVEN SEXUAL ENVIORONMENTS OF CHILDREN

(Johnson, 2003)

1 Natural and Healthy Homes

2 Sexually Neutral Homes

3 Open or Communal Living Homes

4 Sexually Repressed Homes

5 Sex is Dirty Homes

6 Homes with Overt Values and Covert Norms

ELEVEN SEXUAL ENVIORONMENTS OF CHILDREN

(Johnson, 2003)

7 **Sexually Overwhelming Homes**

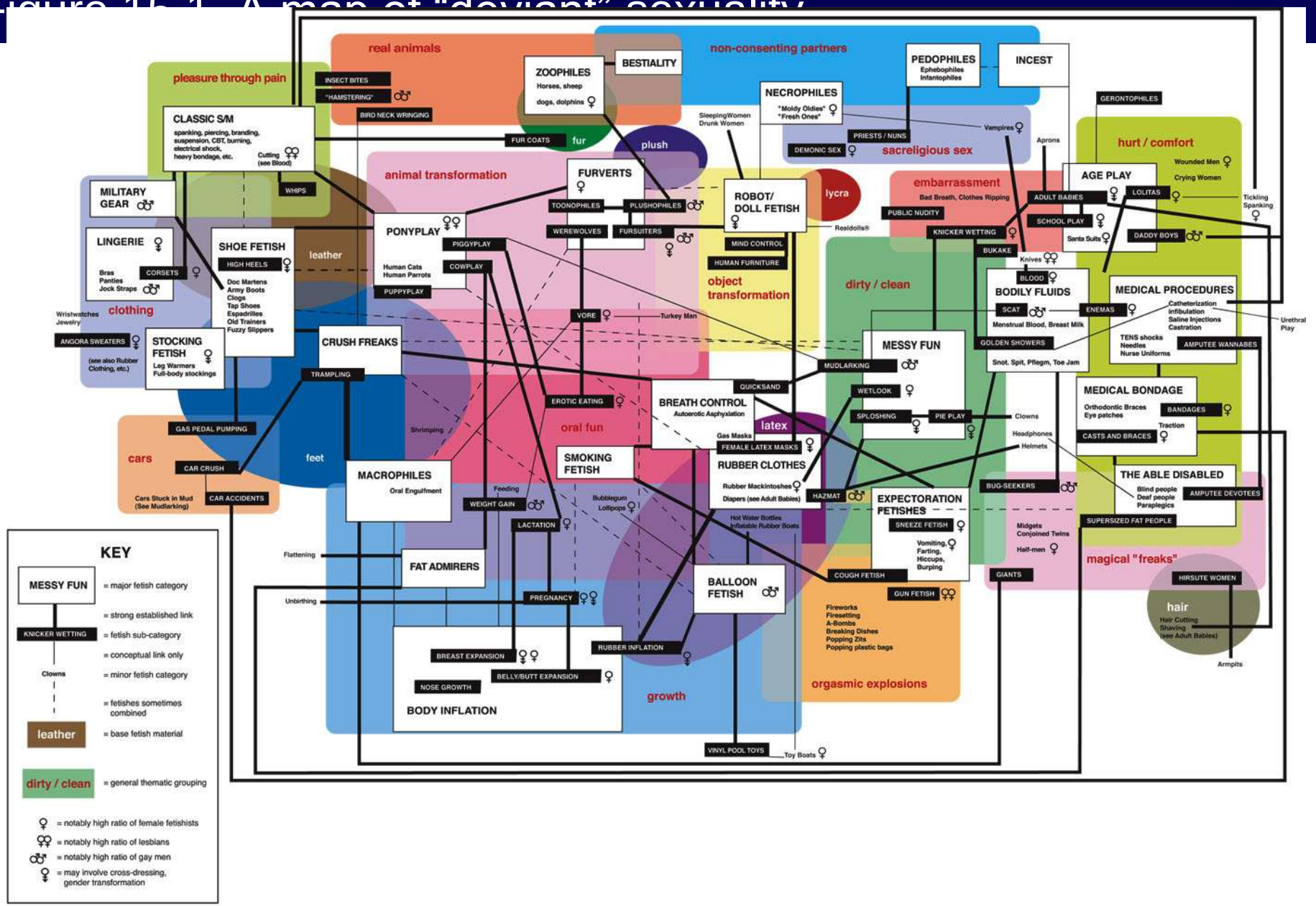
8 **Sexually and Emotionally Needy Homes**

9 **Homes Where Sex is an Exchange Commodity**

10 **Sexually Abusive Homes**

11 **Multigenerational Sexually Abusive Homes**

Figure 15.1 A map of "deviant" sexuality



***HUMAN SEXUALITY 4e*, Figure 15.1**

The Impact of Internet Pornography on Adolescents
Owens, et. al. (2012)

- Impact on Attitudes and Beliefs
- Sexual Behavior
- Sexual Aggression
- Social Development
- The Adolescent Brain
- Self-Concept and Body Form

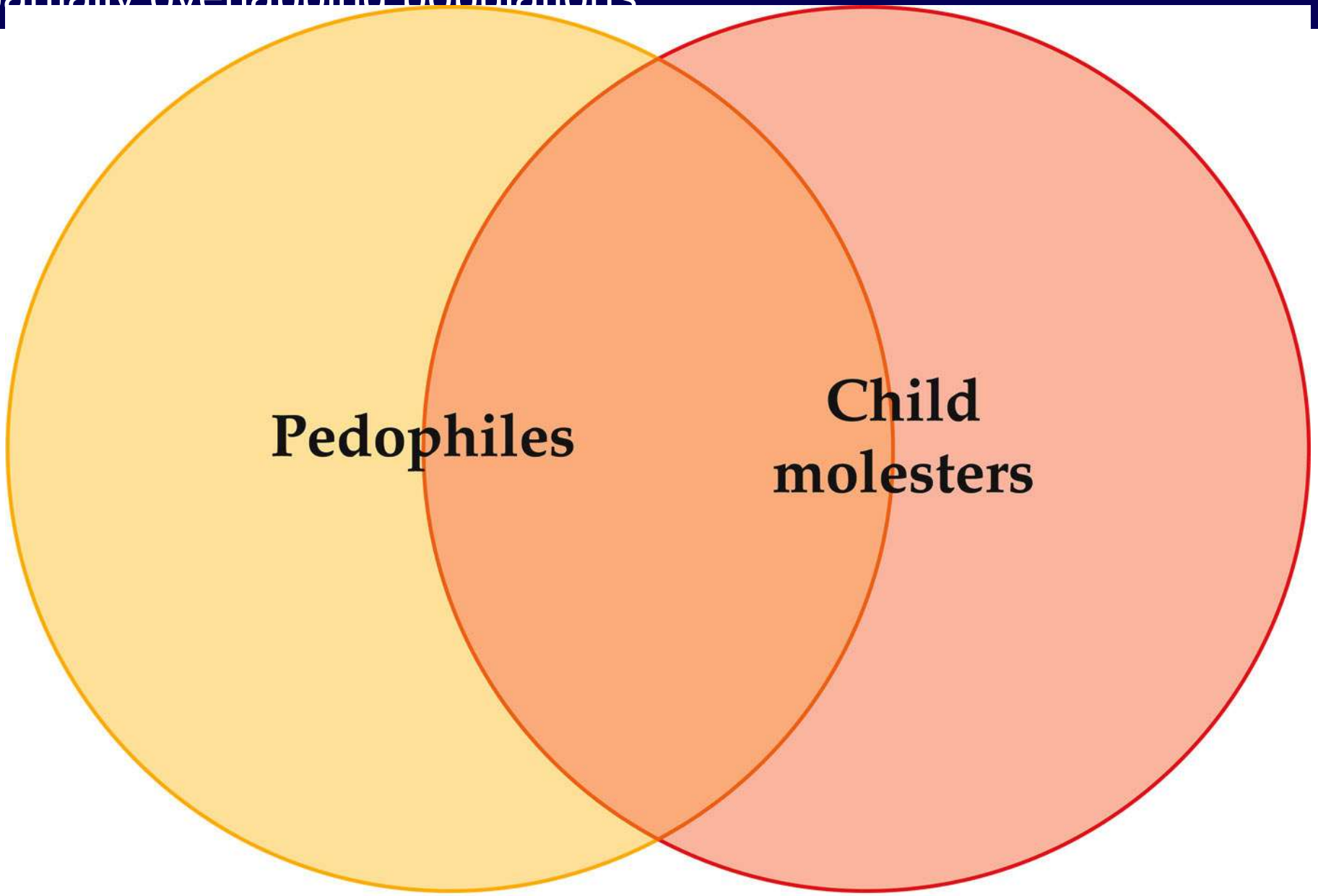
Paraphilias Are Problematic Sexual Desires or Behavior

- The *DSM-5* of the American Psychiatric Association lists 8 specific paraphilias
  - Sexual masochism disorder
  - Sexual sadism disorder
  - Transvestic disorder
  - Exhibitionistic disorder
  - Voyeuristic disorder
  - Frotteuristic disorder
  - Pedohebephilic disorder
  - Paraphilic disorders not otherwise specified

Some Adults Desire Sexual Contact with Children

- Pedophiles and child molesters are not synonymous
- Hebephiles are attracted to children ages 11–14 years, and not all mental health professionals consider this a paraphilia

Figure 15.9 Pedophiles and child molesters are distinct but partially overlapping populations



HUMAN SEXUALITY 4e, Figure 15.9

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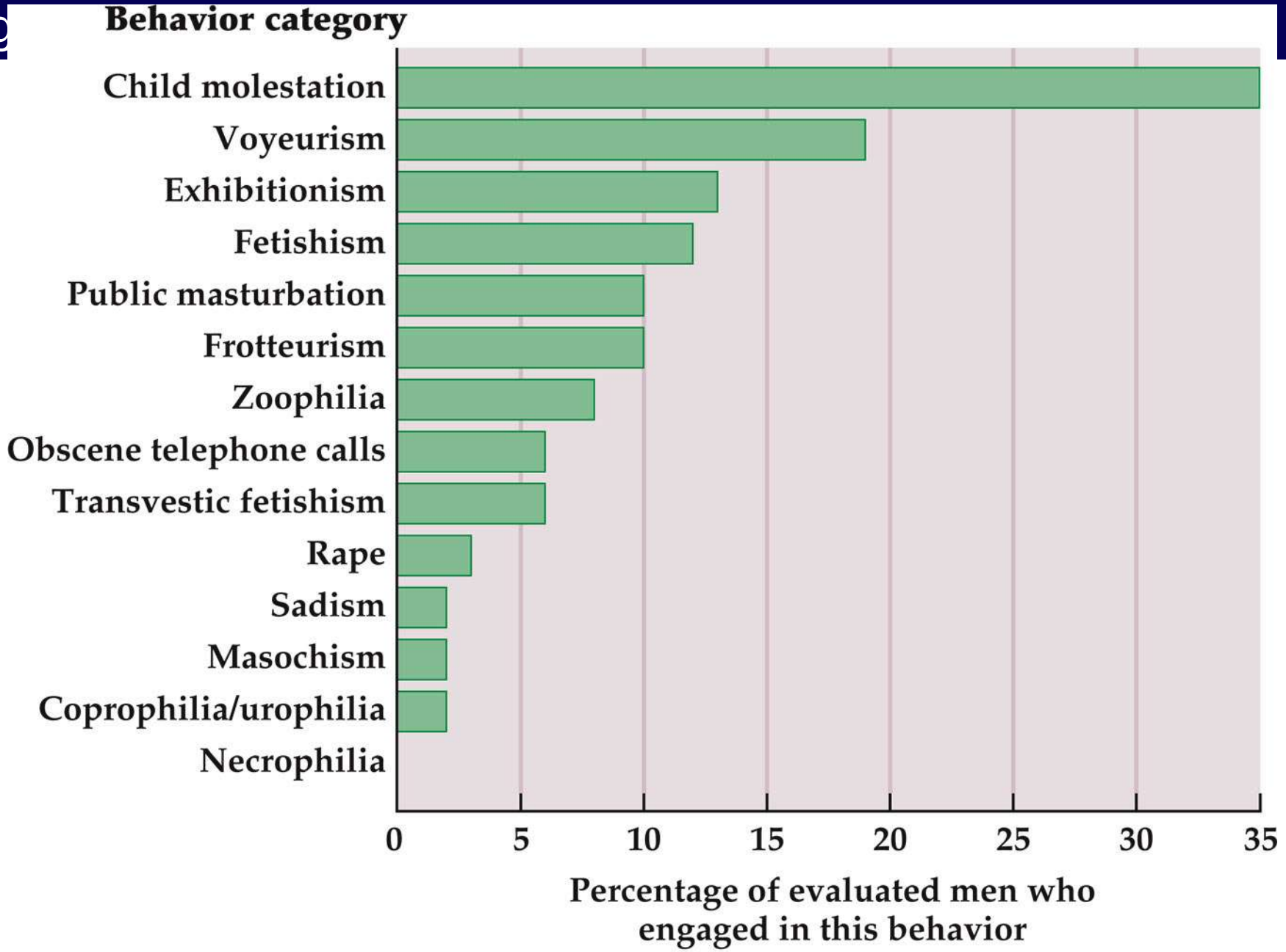
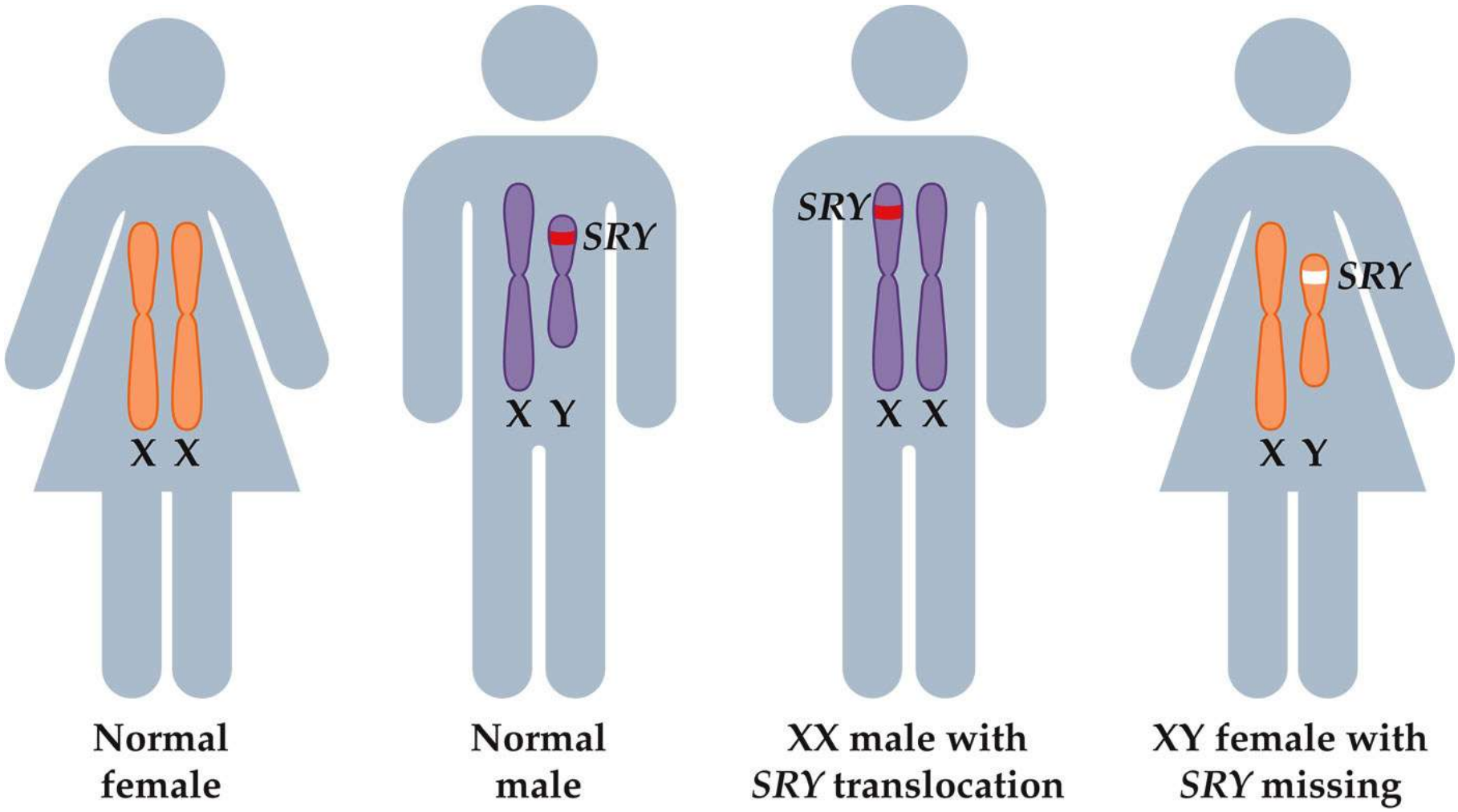


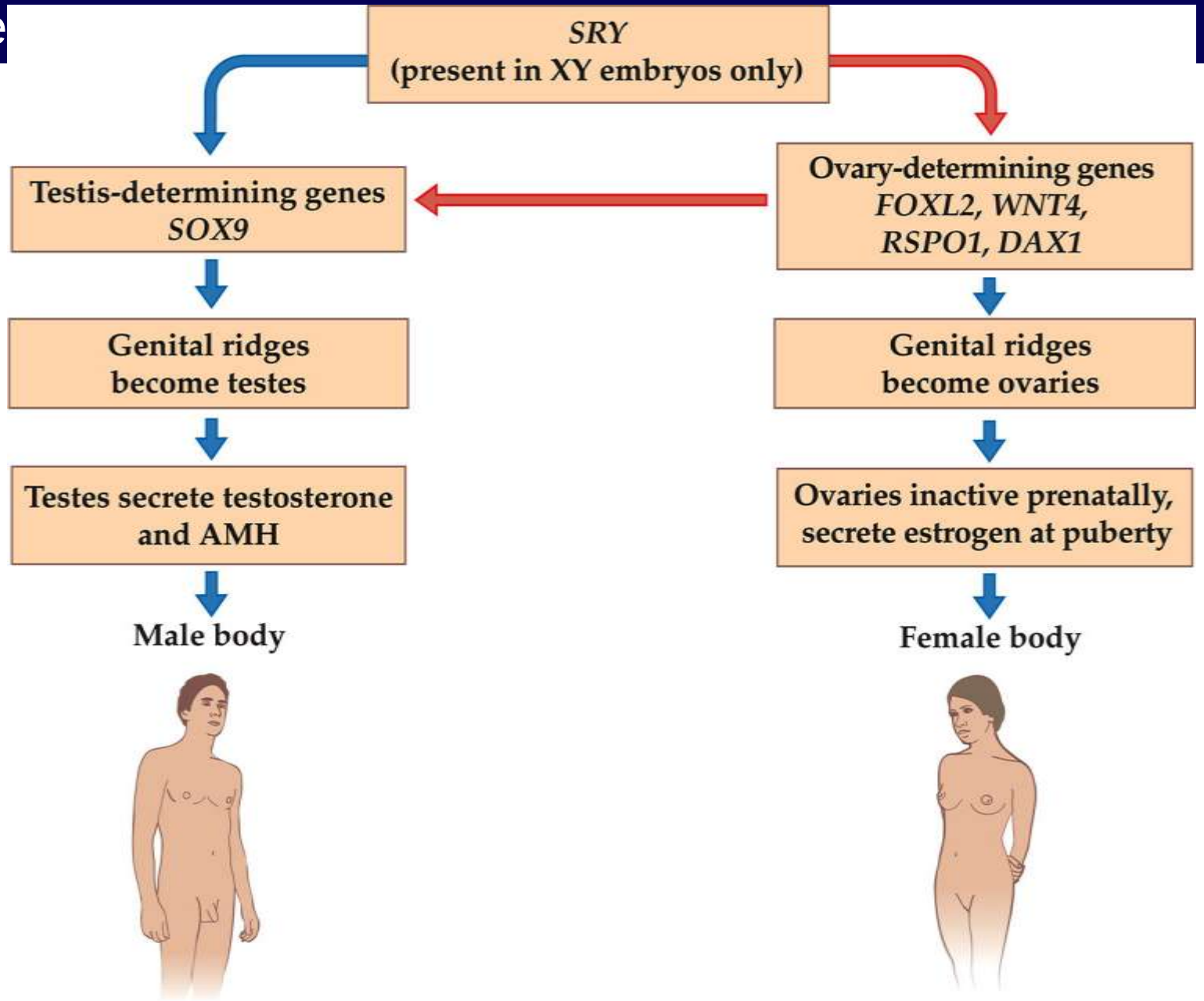
***HUMAN SEXUALITY 4e*, Figure 15.6**

Figure 6.8 The genetic basis of sex determination



HUMAN SEXUALITY 4e, Figure 6.8

Figure

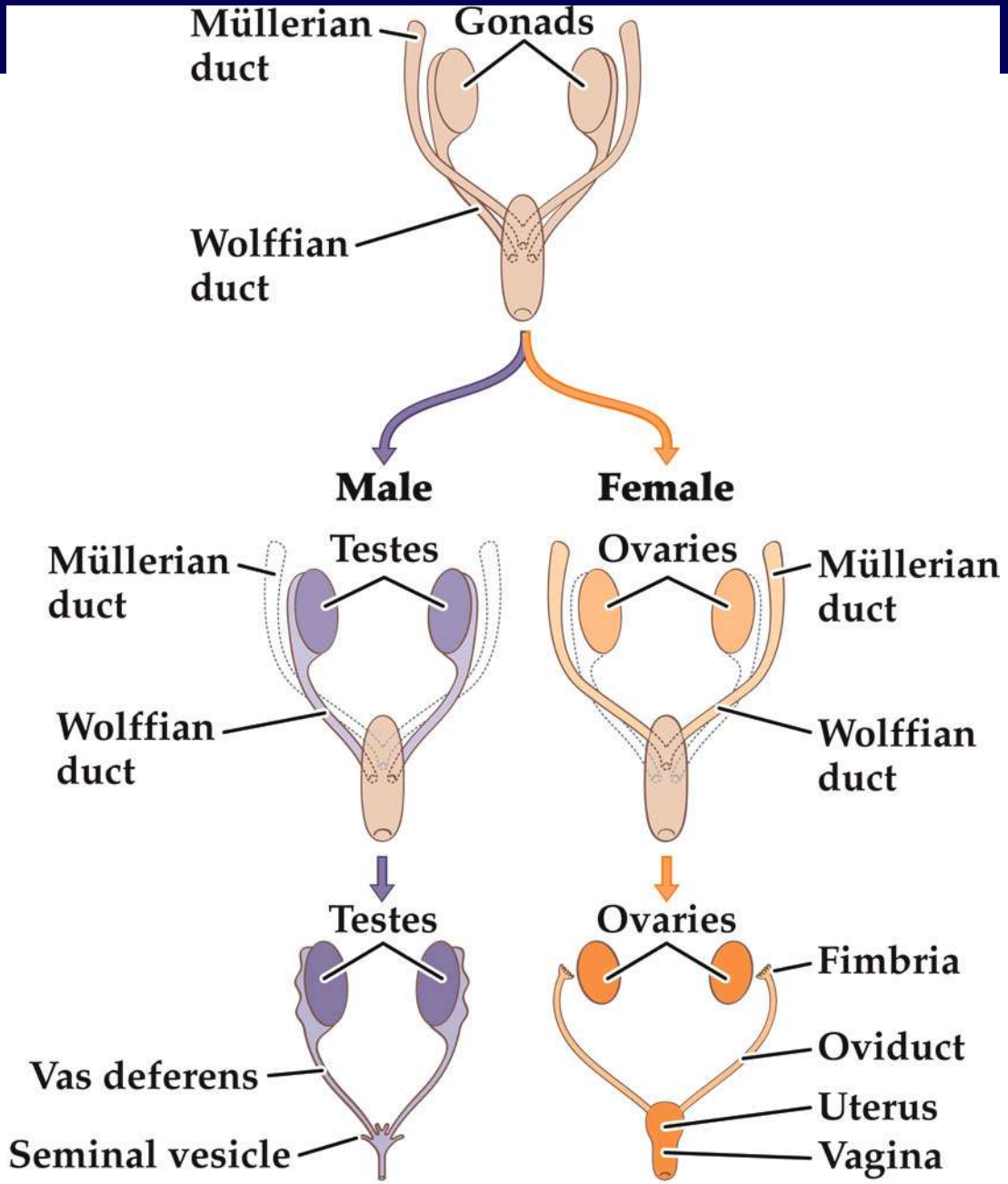


HUMAN SEXUALITY 4e, Figure 6.9

Sexual Development Involves Growth or Breakdown of Precursor Structures

- At 6 weeks postconception, both male and female embryos possess two sets of ducts that run from each gonad to the future site of the external genitalia
  - In male fetuses, testosterone stimulates the Wolffian ducts to develop into the epididymis, vas deferens, ejaculatory ducts, and seminal vesicles, and AMH causes the Müllerian to regress and disappear
  - In female fetuses, in the absence of AMH, the Müllerian ducts develop into the oviducts, uterus, and the deeper part of the vagina, while the Wolffian ducts regress and disappear in the absence of testosterone

Figure 6.11 Development of the male and female reproductive tracts

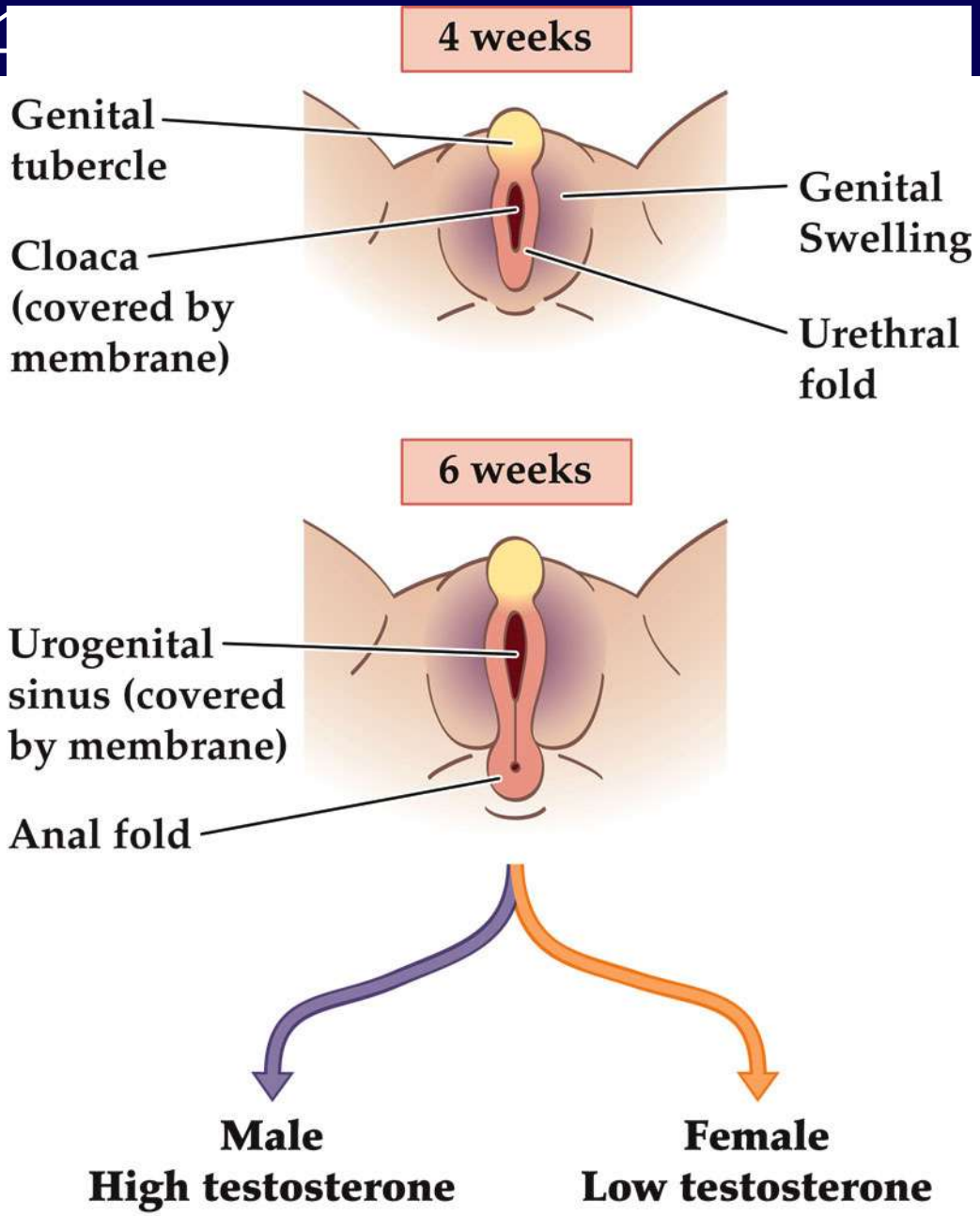


HUMAN SEXUALITY 4e, Figure 6.11

Sexual Development Involves Growth or Breakdown of Precursor Structures

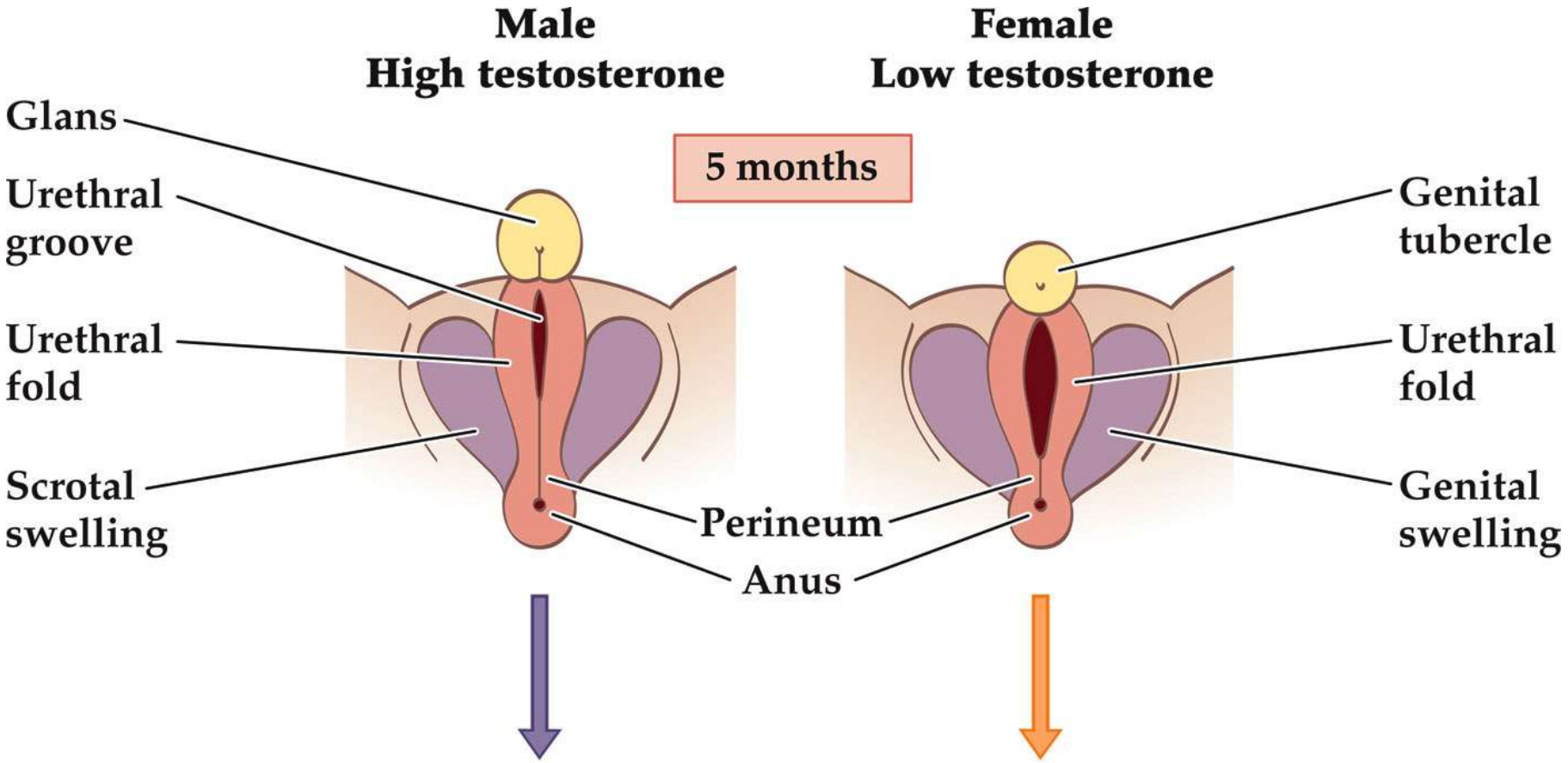
- At this time, the external genitals of male and female embryos are identical and consist of the genital tubercle (forms glans of penis or clitoris), urethral folds (forms shaft of penis or labia minora), and urethral swellings (forms scrotum or labia majora)
  - In male fetuses, testosterone must be converted to 5α-dihydrotestosterone (DHT) for masculinization of the external genitalia to occur
  - In female fetuses, feminization of genitals occurs in the absence of hormonal signals

Figure 6.12 Development of the male and female external genitalia (Part 1



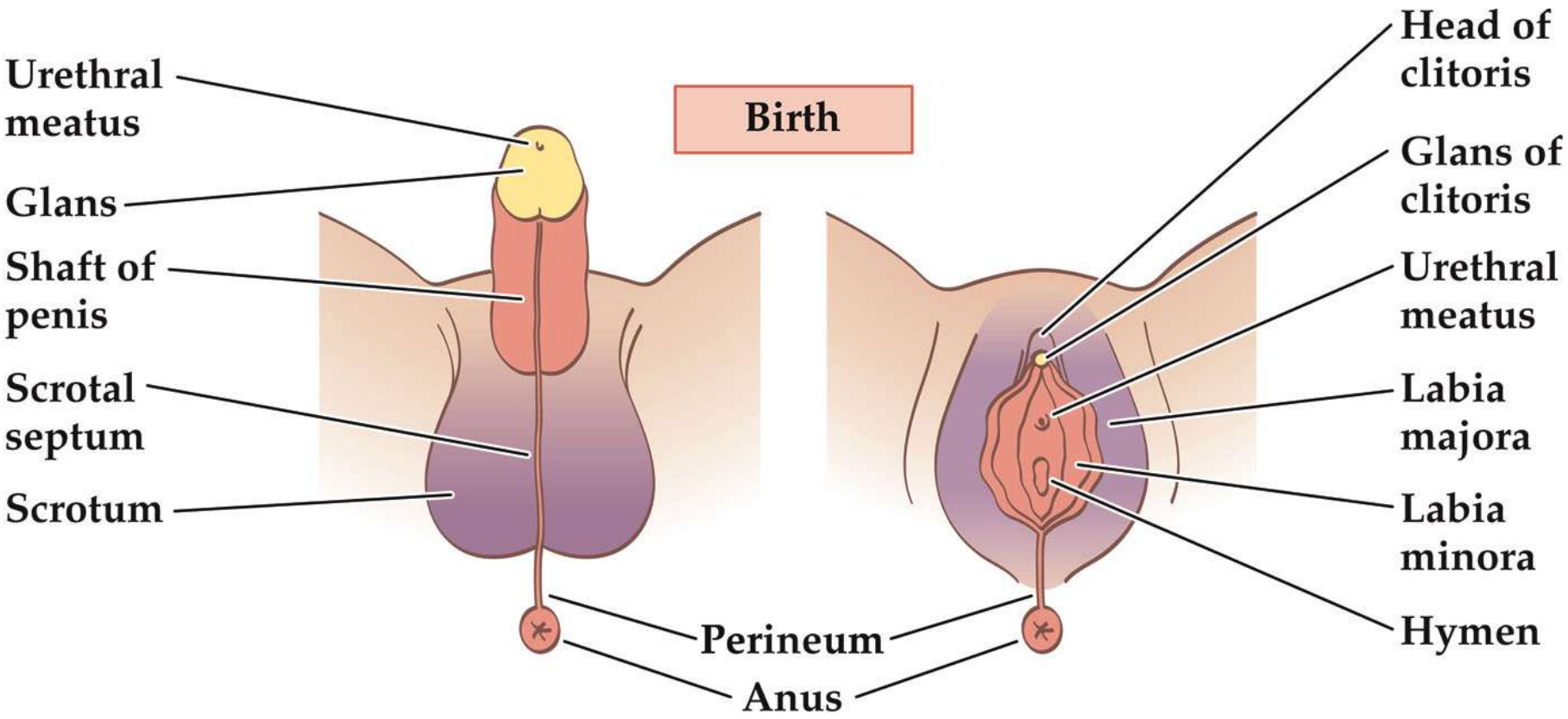
HUMAN SEXUALITY 4e, Figure 6.12 (Part 1)

Figure 6.12 Development of the male and female external genitalia (Part 2)



HUMAN SEXUALITY 4e, Figure 6.12 (Part 2)

Figure 6.12 Development of the male and female external genitalia (Part 3)



HUMAN SEXUALITY 4e, Figure 6.12 (Part 3)

Some Forms of Childhood Sexual Expression Are Common

- The study of childhood sexuality faces practical difficulties
- By the end of the nineteenth century, the belief that children needed to be kept in a state of sexual innocence was fully ingrained in Western culture

Some Forms of Childhood Sexual Expression Are Common

- Children engage in solitary sexual behaviors: penile erections and vaginal lubrication occur in newborn babies. Infants and young children commonly touch their genitals
- Interpersonal sexual activity also occurs during childhood: showing their genitals and viewing the genitals of other children; playing “doctor,” “house,” or “show”
- Cultures vary in their attitudes toward childhood sexuality

TABLE 13.1 Children's Sexual Behavior[a]

BEHAVIOR	GIRLS	BOYS
Talking about sex	28	30
Looking at pornographic pictures	13	22
Kissing and hugging	44	34
Showing genitals	23	28
Other child touching your genitals	19	17
Touching, exploring genitals of other child	19	17
Inserting objects into other child's vagina or rectum	4	10
Other child inserting objects into your vagina or rectum	2	2
Putting penis in other child's mouth	—	5
Other child putting penis in your mouth	1	2
Vaginal intercourse	1	4
Anal intercourse	0	3

Source: Larsson & Svedin, 2002a.

[a]The table shows the percentage of young adults who recalled having engaged in various voluntary sexual activities with other children when they were 6–10 years of age.

Infant and Childhood Sexuality

- Capacity for sexual response present at birth
- Infants engage in self-pleasuring activity
- Unable to differentiate sexual from sensual pleasure
- Sexual behavior is a normal part of development

Childhood Sexuality

- Normative behavior not well studied
- Common behaviors at varying ages
  - 2 - 3 years: masturbation begins
  - 4 - 7 years: sex play begins
  - 5 - 7 years: begin to enact marriage scripts
  - 8 - 9 years: homosociality
  - 10 - 11 years: interest in bodily changes

20 Characteristics of Problematic Sexual Behavior in Children (Johnson, 2004)

1. No ongoing mutual play relationship
2. Different ages or developmental levels
3. Out of balance with other aspects of child's life and interest
4. Too much knowledge
5. Significantly different than other same-age
6. Continues despite clear request to stop
7. Unable to stop themselves
8. Elicit c/o from other children
9. Directed at adults who are uncomfortable
10. Do not know their rights

20 Characteristics of Problematic Sexual Behavior in Children (Johnson, 2004)

11. Progress in frequency, intensity, or intrusiveness over time
12. Fear, anxiety, deep shame or intense guilt associated with sexual behavior
13. Engage in extensive, persistent mutually agreed upon adult-type
14. Manually stimulate or have oral/genital contact with animals
15. Sexualize nonsexual things
16. Cause physical or emotional pain or discomfort to self/others
17. Use sex to hurt others
18. Verbal/physical expressions of anger precede, follow, or accompany
19. Use distorted logic to justify "She didn't say 'no'."
20. Coercion, force, bribery, manipulation, or threats

Preadolescence May Be Marked by an Increase in Sexual Interest

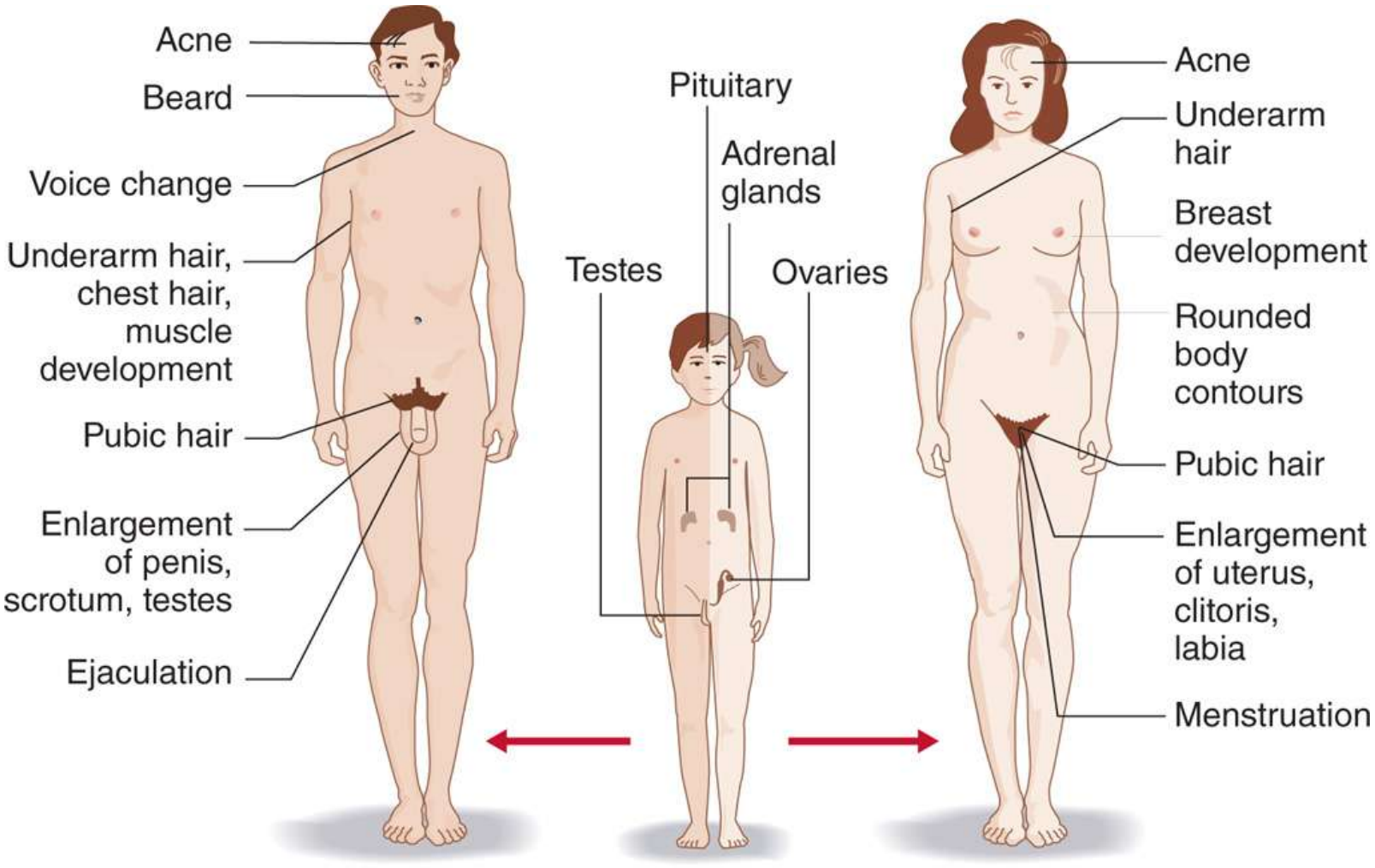
- Preadolescent children segregate by sex.
- Age of first coitus varies among ethnicities
- During preadolescent years gender norms become stricter
- Strict gender norms may traumatize children who become gay adults

Physical Changes in Adolescence

Puberty

- Reproductive organs mature
- Onset 8 - 14 years old; 2 years earlier in girls
- Triggered by release of gonadotropins
- Signals testes and ovaries

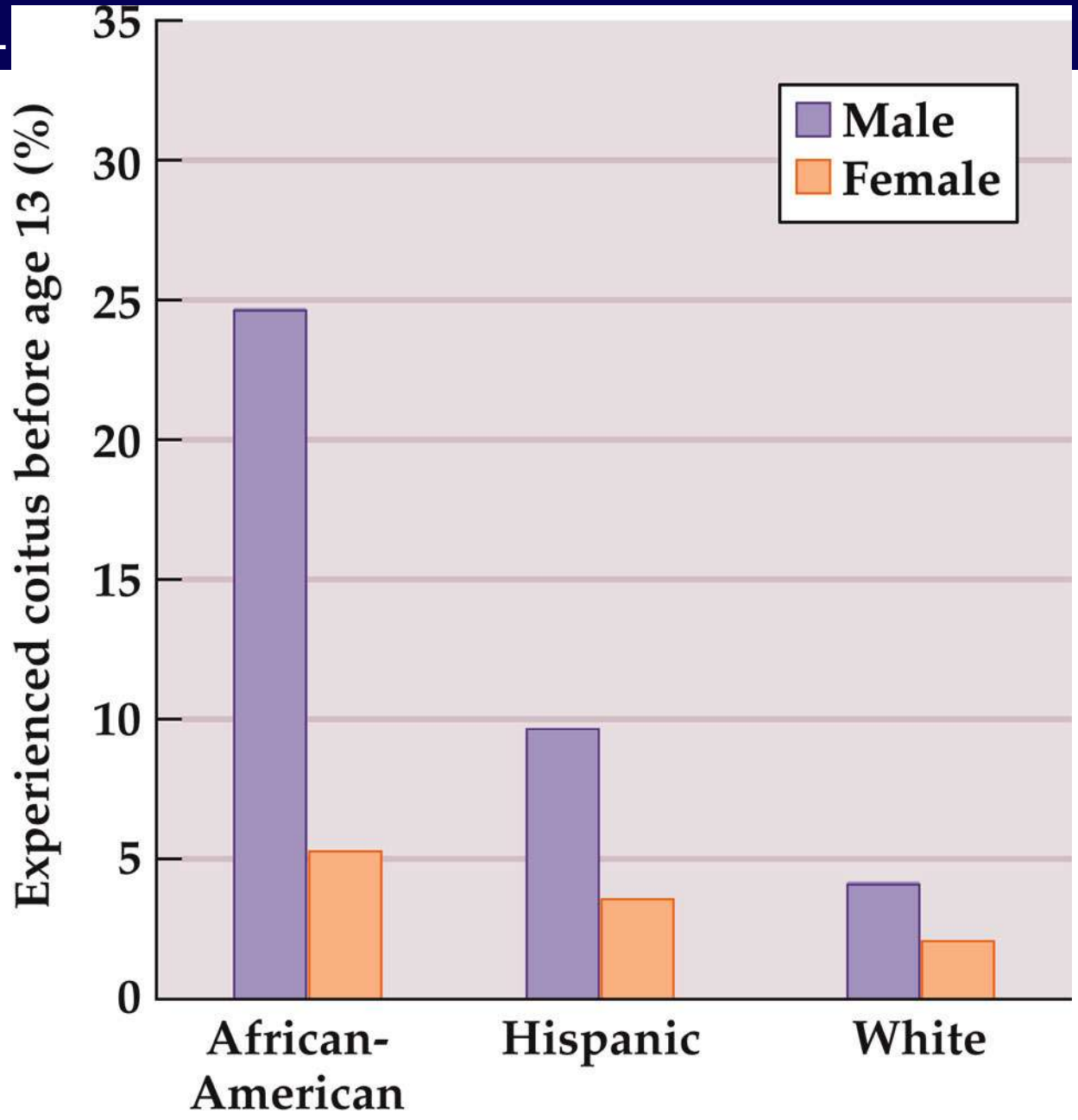
Puberty



Secondary Sex Characteristics During Puberty

- **Both Sexes**
  - Pubic hair, growth spurt
  - Genitals enlarge, axillary oil-secretion
- **Girls**
  - Breast buds
  - Voice changes
- **Boys**
  - Facial hair
  - Voice deepens

Figure 13.1

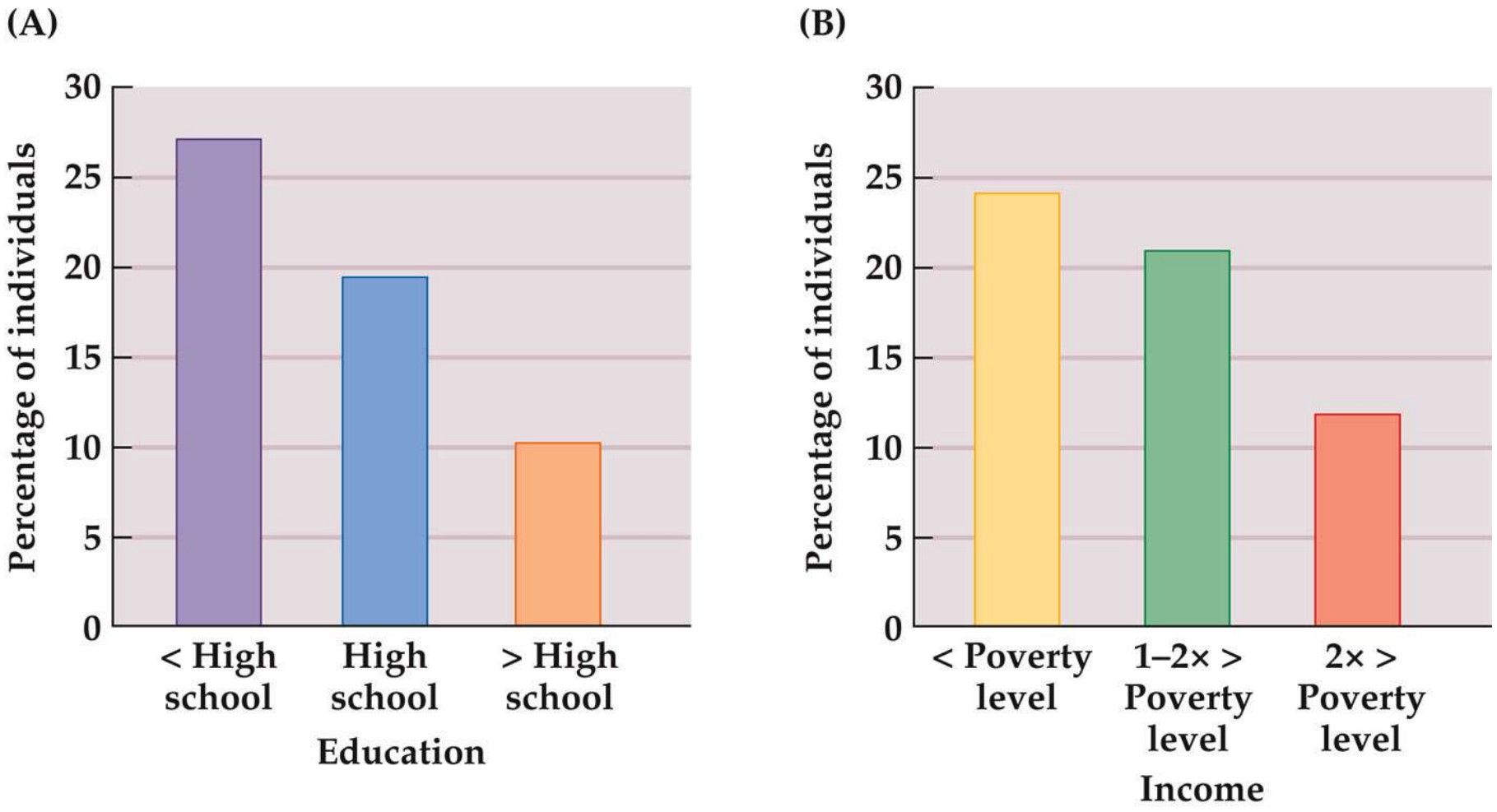


***HUMAN SEXUALITY 4e*, Figure 13.1**

Adolescence Is a Time of Sexual Exploration

- Social influences such as education level and income influence teen sexual behavior
- Males masturbate more often than females

Figure 13.2 Social influences on early sex



HUMAN SEXUALITY 4e, Figure 13.2

Primary Sex Characteristics During Puberty

- Girls
  - Thicker vaginal walls and larger uterus
  - Vaginal secretions
  - Menarche: average age 12 or 13
- Boys
  - Larger prostate and seminal vesicles
  - First ejaculation around 13
- Physical changes can be sources of pride or concern for girls and boys

The Sexual Double Standard

- Gender-role differentiation increases in adolescence

- Girls
  - Focus on sexuality = relationship
  - Dilemma: to appear sexy to attract males but not to appear “easy”

- Boys
  - Focus on sexuality = conquest
  - Peers reinforce aggressive and independent behaviors

Masturbation in Adolescence

- Increase in frequency and numbers
- Safe sexual release
- Way to learn about self

Non-Coital Sexual Expression in Adolescence

- Kissing, holding, touching, manual, and oral stimulation of genitals
- Oral-genital activity has increased
- Learning about sexual intimacy
- Question of technically staying a virgin

Ongoing Sexual Relationships During Adolescence

- More common at this age than in past

- Narrowing of gender gap
  - Girls less likely to “save themselves” for marriage
  - Boys more likely to want an affectionate relationship

Sexual Intercourse During Adolescence

- Adolescent coitus
  - National upward trend reached plateau in last 10 years

- Age of first coitus has decreased over last several decades

Reasons for Sexual Intercourse During Adolescence

- Acceleration of sex hormones
- Curiosity and sense of readiness
- Affection for partner
- Push to adult behavior
- Peer pressure, date pressure

Predisposing Factors for Early/Late Coitus in Adolescents

- Early Coitus
  - Poverty
  - Family conflict
  - Parental lack of education, supervision
  - Parental substance abuse
- Late Coitus
  - Strong religious beliefs
  - Good grades
  - Higher SES
  - High quality parent-child relationship and communication

Same-Sex Experiences in Adolescence

- Experimental or transitory same-sex sexual contact between peers is common
- Some individuals begin to self-identify as lesbian, gay, and bisexual in teen years
- Often encounter negative societal reactions
- Reconciling orientation can be difficult; often face rejection from peers and family

Some Children Have Sexual Contacts with Adults

- Certain kinds of adult–child sex are more harmful than others. Those that are more harmful include coerced sex, repeated sexual contacts, incest, and sexual penetration
- Adult–child sex and its consequences are complicated by problems of recall
- Strategies to prevent adult–child sex are effective

TABLE 13.2 Percentage of Adult–Child Sexual Contacts Identified by Relationship and Child's Sex

RELATIONSHIP OF ADULT TO CHILD	CHILD'S SEX	
	GIRL	BOY
Father	7	1
Stepfather	7	1
Older brother	9	4
Other relative	29	13
Teacher	3	4
Family friend	29	40
Mother's boyfriend	2	1
Older friend of child	1	4
Other person known to child	19	17
Stranger	7	4

Source: NHSLS.

Note: The percentages add up to more than 100 because some children had contacts with more than one adult.

***HUMAN SEXUALITY 4e*, Table 13.2**

Teens Less Likely than Adults to Use Birth Control Correctly

- Lack of adequate knowledge
- Planning ahead implies loose morals
- Fear of pelvic exam
- Embarrassment
- Confidentiality concerns
- Less stable relationships
- Difficulty communicating with partner

Strategies to Reduce Teen Pregnancy

- Free, confidential contraceptive services
- Compulsory national sex-education
- Focus on shared responsibility for birth control
- Relaxed governmental restrictions

Sex Education
Answering Children's Questions About Sex

- Start early, ongoing discussion
- If uncomfortable, share information through print or visual media
- Make answers direct, honest, and at child's level of understanding
- Make child aware of physiological changes before they happen
- Young people prefer their parents as primary source of sex information

- Quality of programming varies
- Most parents support such programs
- Abstinence-only sex education programs do not delay first intercourse or affect attitudes about sex
- Research shows that sex education programs do not increase sexual experimentation nor restraint, but they do decrease high-risk behavior

Healthy Adolescent Sexual Development

(Bukowski, Sippola, & Brender, 1993)

1. Learning about intimacy through interactions with peers
2. Understanding of personal roles and relationships, inside and outside the family
3. Revising or adapting one's body schema to changes in physical size, shape, and capabilities, especially during early adolescence

Healthy Adolescent Sexual Development

(Bukowski, Sippola, & Brender, 1993)

4. adjusting to erotic feelings and experiences, and integrating them into one's life
5. learning about societal standards and practices regarding sexual expression
6. developing an understanding and appreciation of reproductive processes

Ways to be Involved (Palkovitz, 1997)

- Communication
- Teaching
- Monitoring
- Thought Processes
- Errands
- Caregiving
- Child-related Maintenance
- Shared Interests
- Availability
- Planning
- Shared Activities
- Providing
- Affection
- Protection
- Supporting Emotionally

Creating New Meanings

Women's Sexuality Across the Life Span (Daniluk, 1998)

- **Sexual Semantics**
- **"Me Tarzan, You Jane" Approach to Sex**
- **"Dear Abby"**
- **"Embodied" Sexuality**
- **Self-Defined Sexuality**
- **Rewriting Sexual Scripts**
- **The Personals Are Political**
- **"Vavoom" Experiences**
- **Self-Care**

“Nothing Works” Philosophy

R. Martinson, 1970 -1980s

Psychiatry and Sex Psychopath Legislation: The 1930’s to the 1980’s

Furby, Weinrott, and Blackshaw (1989) Psychological Bulletin

Myth: Treatment Doesn't Work Facts: Treatment can help

- Furby, Weinrott, & Bradshaw (1989).
  - Combined analysis of numerous studies that was unable to detect a significant treatment effect due to methodology variability.
- Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002).
  - 17% untreated
  - 10% treated

  -Equivalent to a 40% reduction
- Losel, F., & Schmucker, M. (2005).
  - Recidivism reduced by nearly 40%

- SOTEP:
  - No overall differences between treated and untreated groups, but:
- Sex offenders who successfully completed the SOTEP treatment program reoffended at lower rates than those who did not demonstrate that they "got it" (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005).

Can they be cured?

- Treatment won't work equally well for everyone, and 100% success should not be expected.
- Sex offender treatments, like many other types of medical and mental health interventions, don't focus on a cure but on a reduction of symptoms.
- Treatment for diabetes doesn't cure the disease, it manages the disease. Likewise, entering weight watchers with the expectation that simply being in the program will create weight reduction won't work. It takes collaboration and commitment.

Can they be cured?

- Treatment for schizophrenia doesn’t cure psychosis, it reduces symptoms and allows people to function more adequately.
- Chemotherapies may not ultimately prevent all cancer fatalities but may increase life expectancy and quality of life for many patients.
- Sex offender treatment teaches clients how to change their thinking and their behavior, and many are able and willing to do so and avoid reoffense.

Fact: Re-offense rates for juveniles are lower than most think

- Reitzel & Carbonell (2006) summarized published and unpublished data from 33 studies on JSA recidivism
- Average 56-month follow-up period
- 9 studies contained a no treatment control group (*n* = 4) or a comparison treatment group (*n* = 5)
- Treated adolescents recidivated sexually at a lower rate (7.37%) than untreated adolescents (18.93%; Total *N* = 2986)

Walker, McGovern, Poey, & Otis (2004)

- Meta-analysis of 10 studies (N=644)
- “Results were surprisingly encouraging”
- Effect size – **r=.37**
- Cognitive-Behavioral approaches most effective

Vandiver, 2006

- 300 registered male offenders; <18 at the time of their arrest (avg. was 15)
- 3-6 year follow-up
- *N* = 13 arrested for a sex offense
  - Of those, 4 arrested 2x & 1 arrested 3x
- More than 50% arrested for non-sexual crime

Recidivism Studies of Juvenile Sex Offenders

Alexander, M.A. (1999). Sexual offender treatment efficacy revisited. Sexual Abuse: Journal of Research and Treatment, 11, 101-116.

Becker, J.V. (1998). What we know about the characteristics and treatment of adolescents who have committed sexual offenses. Child Maltreatment, 3, 317-329.

Borduin, C.N., Henggler, S.W., Blaske, D.N., & Stein, R.J. (1990). Multi-systemic treatment of adolescent sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 34, 105-113.

Recidivism Studies of Juvenile Sex Offenders

Hagen, N.P., & Cho, N.E. (1996). A comparison of treatment outcomes between adolescent rapists and child sex offenders. International Journal of offender Therapy and Comparative Criminology, 40,113-122.

McMahon, P.M., & Puett, R.C. (1999). Child sexual abuse as a public health issue: Recommendations of an expert panel. Sexual Abuse: A Journal of Research and Treatment, 11, 257-266.

Schram, D.D., Milloy, C.D., & Rowe, W.E. (1991). Juvenile sex offenders: A follow-up study of reoffense behavior. Washington: Urban Policy Research.

Juveniles Who Commit Sex Offenses Against Minors (2009)

- Juveniles account for more than one-third (35.6 percent) of those known to police to have committed sex offenses against minors. However, they account for only 3.1 percent of all juvenile offenders and 7.4 percent of all violent juvenile offenders.

- Juveniles who commit sex offenses against other children are more likely than adult sex offenders to offend in groups and at schools and to have more male victims and younger victims.

- The number of youth coming to the attention of police for sex offenses increases sharply at age 12 and plateaus after age 14. Early adolescence is the peak age for offenses against younger children. Offenses against teenagers surge during mid to late adolescence, while offenses against victims under age 12 decline.

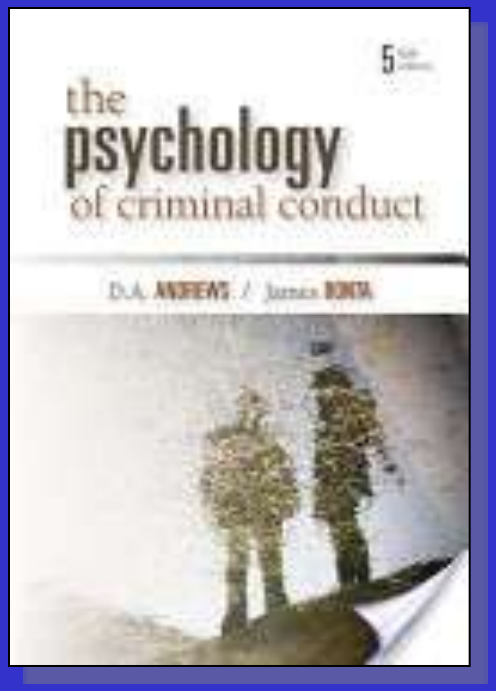
Juveniles Who Commit Sex Offenses Against Minors (2009)

- A small number of juvenile offenders— 1 out of 8—are younger than age 12.
- Females constitute 7 percent of juveniles who commit sex offenses.
- Females are found more frequently among younger youth than older youth who commit sex offenses. This group's offenses involve more multiple-victim and multiple-perpetrator episodes, and they are more likely to have victims who are family members or males.
- Jurisdictions vary enormously in their concentration of reported juvenile sex offenders, far more so than they vary in their concentration of adult sex offenders.

Andrews & Bonta (2010)

Three Principles:

- Risk
- Need
- Responsivity



From The Psychology of Criminal Conduct, 5th ed.

Returning to the basics

- Not everyone is ready to change, and some people change despite our efforts

- Readiness
- Responsivity

Does the Youngster Have:

1) The *capacity* of the youngster's caregivers, with therapeutic support, to stop their own destructive behavior – such as maltreatment – and to move in the direction of greater competence, more effective limit setting, and better maintenance of generational boundaries;

(Efrain Bleiberg, *Treating Personality Disorders in Children and Adolescents*, 2001)

Does the Youngster Have:

2) The *availability* of community resources and services such as in-school support services, in-home crisis stabilization, and office- and home-based family treatment that can be mobilized to support the caregiver's competence; and

3) The extent of the youngster's need for *containment and structure* to prevent behavior dangerous to self or others.

(Efrain Bleiberg, *Treating Personality Disorders in Children and Adolescents*, 2001)

Effective Programs

RISK Principle

- effective programs match the level of treatment intensity to the level of risk posed by the offender
- high risk = high intensity
- mismatching can result in increased risk

Effective Programs

NEED Principle

- effective programs target identified criminogenic needs
- sex offenders require sex offender specific treatment programming
- other programs may result in some ancillary gain, but risk for sexual recidivism likely will not be reduced

Effective Programs

RESPONSIVITY principle

- effective programs are those which are responsive to offender characteristics
  - cognitive abilities
  - maturity
  - motivation
  - mode of intervention
  - scheduling concerns

Effective Programs

PROFESSIONAL DISCRETION

- in every effective correctional intervention, there must be a coordinated plan which takes risk, need, and responsivity into consideration
- someone must be “driving the bus”
- sometimes, exceptions to the first three principles can be justified based on global perspectives

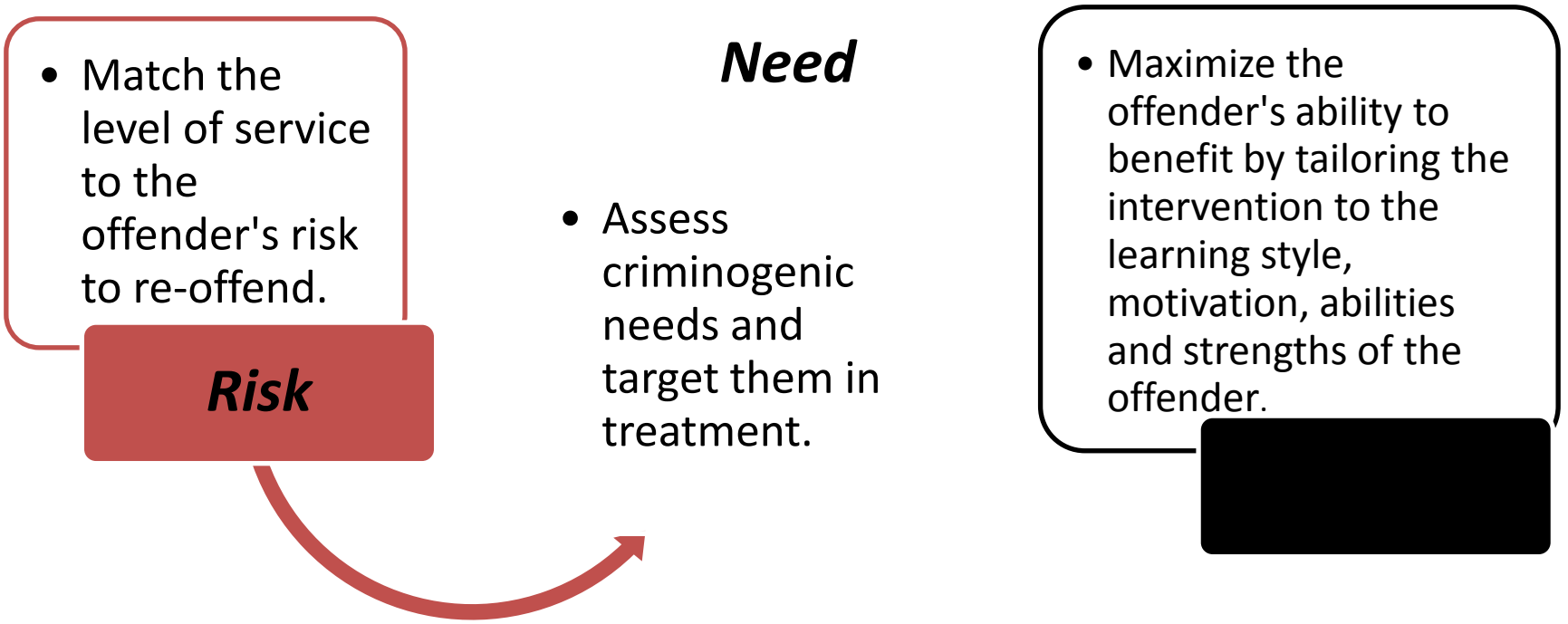
Treatment of Sexual Offenders

- Historically, many types of treatment interventions applied to sexual offenders
- Current effective practice:
  - Adherence to principles of risk, need, responsivity
  - Assessment of risk factors/criminogenic needs
  - Cognitive-behavioral intervention
  - Treatment that targets identified risk factors/criminogenic needs
  - Post-treatment maintenance/follow-up programming

Treatment of Sexual Offenders

- Treatment is cognitive-behavioral:
  - Change patterns of affect, cognition, behavior
  - Development of pro-social/non-offending attitudes and beliefs
  - Acquisition and rehearsal of skills
- Targets dynamic risk factors (e.g., deviant arousal/fantasy/preference, attitudes/cognitive distortions, intimacy deficits, etc.)
- Most common type of intervention presently is relapse prevention (RP), but…
  - Professionals are increasingly adopting the good lives and self-regulation models

Three principles:



Andrews, D. A., and Bonta, J. (2007). *The psychology of criminal conduct (4th ed.). Cincinnati, OH: Anderson Publishing.*

Hanson, R. K., Bourgon, G., Helmus, L., and Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A Meta-Analysis. *Criminal Justice and Behavior, 36(9), 865-891.*

Risk Principle

1.
   - Evidence-based risk assessment instruments
   - Static & Dynamic Risk
2.
   - Properly match level of service to offender risk.
   - Less risk, less tx; more risk, more tx.
3.
   - Maximize resources

Need Principle

Table 1. The seven major risk/need factors along with some minor risk/need factors

Major risk/need factor	Indicators	Intervention goals
Antisocial personality pattern	Impulsive, adventurous pleasure seeking, restlessly aggressive and irritable	Build self-management skills, teach anger management
Procriminal attitudes	Rationalizations for crime, negative attitudes towards the law	Counter rationalizations with prosocial attitudes; build up a prosocial identity
Social supports for crime	Criminal friends, isolation from prosocial others	Replace procriminal friends and associates with prosocial friends and associates
Substance abuse	Abuse of alcohol and/or drugs	Reduce substance abuse, enhance alternatives to substance use
Family/marital relationships	Inappropriate parental monitoring and disciplining, poor family relationships	Teaching parenting skills, enhance warmth and caring
School/work	Poor performance, low levels of satisfactions	Enhance work/study skills, nurture interpersonal relationships within the context of work and school
Prosocial recreational activities	Lack of involvement in prosocial recreational/leisure activities	Encourage participation in prosocial recreational activities, teach prosocial hobbies and sports

Need Principle

Non-criminogenic, minor needs	Indicators
Self-esteem	Poor feelings of self-esteem, self-worth
Vague feelings of personal distress	Anxious, feeling blue
Major mental disorder	Schizophrenia, manic-depression
Physical health	Physical deformity, nutrient deficiency

- **Housing**
- **Employment**
- **Social Support**

Developing a Contextual Matrix

Web of Meaning (Ryan, et al., 1999)

1. What will make me feel better? (*compensation*)
2. How can I get back a sense of control? (*control seeking*)
3. How can I share these bad feelings in order to express my own experience or dilute the effects? (*validation*)
4. How can I get back at those who are perceived to be the source of my vulnerability? (*retaliation*)

Common Drugs Associated with Date Rape

(Pope & Shouldice, 2001)

1. Rohypnol (Roaches, Roofies, Forget Pill)
2. GHB (Liquad Ecstasy, Natural Sleep 500, Soap)
3. Ketamine (K, Special K, Vitamin K, Super Acid)
4. MDMA (Ecstasy, Roll, Adam)
5. Cannabis
6. Barbiturates

The Adolescent Sex Offender's Family in Treatment

- Denial, Minimization, and Projection of Blame
- Lack of Empathy
- Abuse of Power, Powerlessness, Empowerment
- Anger Management
- Intergenerational Abuse
- Family Secrets
- Blurred Role Boundaries
- Human Sexuality
- Divided Loyalty
- Contracts, Surveillance, and Maintenance Strategies

What Every Child Needs

- Respect
- Attention
- Praise
- Protection
- Play
- Consistency
- Models
- Support/An Ally
- Loving Touch
- Assurance

What Every Child Needs

Opportunities to learn without punishment or pressure

Acceptance of himself as an individual, not replica of parents, older sibling, etc.

Thoughtful socialization, rather than cookie cutter conformity

Permission to feel and express

Age appropriate challenges and choices

Generative Work

(Dollahite, Hawkins, & Brotherson, 1997)

- **DEPENDENCE**
  Biophysical/Psychosocial
- **SCARCITY**
  Material/Temporal
- **CHANGE**
  Systematic/Chaotic
- **INTERDEPENDENCE**
  Interpersonal/Emotional
- **ETHICAL WORK**
- **STEWARDSHIP**
- **DEVELOPMENT**
- **RELATIONSHIP**

Generative Work

(Dollahite, Hawkins, & Brotherson, 1997)

- **Commit/Choose** • **MORAL**
- **Create/Consecrate** • **PRODUCTIVE**
- **Care/Change** • **MATURE**
- **Connect/Comm.** • **LOVING**