U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Juveniles Who Have Sexually Offended

A Review of the Professional Literature

OJJDP Report

Office of Juvenile Justice and Delinquency Prevention

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) was established by the President and Congress through the Juvenile Justice and Delinquency Prevention (JJDP) Act of 1974, Public Law 93–415, as amended. Located within the Office of Justice Programs of the U.S. Department of Justice, OJJDP's goal is to provide national leadership in addressing the issues of preventing and controlling juvenile delinquency and improving the juvenile justice system.

OJJDP sponsors a broad array of research, demonstration, and training initiatives to improve State and local juvenile programs and to benefit private youth-serving agencies. These initiatives are carried out by seven components within OJJDP, described below.

Research and Program Development Division develops knowledge on national trends in juvenile delinquency; supports a program for data collection and information sharing that incorporates elements of statistical and systems development; identifies the pathways to delinquency and the best methods to prevent, intervene in, and treat it; and analyzes practices and trends in the juvenile justice system.

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The mission of OJJDP is to provide national leadership, coordination, and resources to prevent and respond to juvenile offending and child victimization. OJJDP accomplishes its mission by supporting States, local communities, and tribal jurisdictions in their efforts to develop and implement effective, multidisciplinary prevention and intervention programs and improve the capacity of the juvenile justice system to protect public safety, hold offenders accountable, and provide treatment and rehabilitative services tailored to the needs of individual juveniles and their families.

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Office of Juvenile Justice and Delinquency Prevention

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Foreword

Sex offenses committed by juveniles are a serious problem. Nearly 16 percent of the arrests for forcible rape in 1995 and 17 percent of the arrests for all other sex offenses in 1995 involved youth under the age of 18. Perhaps even more disturbing are the indications that one in two adult sex offenders began sexually abusive behavior as a juvenile.

The costs imposed by juvenile sex offending are considerable, not only those inflicted on crime victims and society as a whole, but also those imposed on offenders and their families.

As with other delinquent behaviors, early intervention can be critical. Unfortunately, many programs used to treat juveniles who have committed sex offenses appear to apply interventions derived from our knowledge of adult sex offenders without adequate attention to the unique developmental needs of youth.

The authors of *Juveniles Who Have Sexually Offended* have diligently mined the research literature to provide a comprehensive and annotated account of the characteristics of juveniles who commit sex offenses and their families, and the type of offenses they commit.

A broad array of clinical assessment tools, including psychological testing, are described, and a thorough discussion of recidivism rates and issues is presented. The Report concludes with a review of treatment approaches and settings and a look at program assessment.

Youth who have committed sex offenses both have developmental needs and pose unique risks related to their abusive behaviors. The information provided by the review of the professional literature presented in this Report should enable us to better address those needs and risks.

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This Report provides a convenient and up-to-date review of the literature and a discussion of the pragmatics of professional work with juveniles who have committed sex offenses. The authors hope that the review will assist caseworkers, clinicians, legal professionals, and others who work with these juveniles. Although this work often is difficult and challenging, combined efforts can make a difference.

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Executive Summary

Introduction

Sexual abuse is widely recognized as a significant problem in society, and the scope of the problem may be underestimated because juvenile sex offenders who are known to the system may represent only a small proportion of juveniles who have committed such offenses. Studies of adult sex offenders suggest another dimension of the problem: many of these offenders began their sexually abusive behavior in their youth.

The costs of sex offending are substantial for victims and society and for the young offenders and their families. To minimize these costs, timely and appropriate interventions are needed. A review of the professional literature suggests, however, that programs designed to meet the perceived needs of these young offenders frequently apply knowledge and interventions designed for adult offenders without considering developmental issues and needs unique to juveniles.

Characteristics of Juveniles Who Have Committed Sex Offenses

Juveniles who have committed sex offenses are a heterogeneous mix (Bourke and Donohue, 1996; Knight and Prentky, 1993). They differ according to victim and offense characteristics and a wide range of other variables, including types of offending behaviors, histories of child maltreatment, sexual knowledge and experiences, academic and cognitive functioning, and mental health issues (Knight and Prentky, 1993; Weinrott, 1996).

Offending Behaviors

Sexually abusive behaviors and sex offense characteristics. Sexually abusive behaviors range from noncontact offenses to penetrative acts. Offense characteristics include factors such as the age and sex of the victim, the relationship between victim and offender, and the degree of coercion and violence used.

Nonsexual criminal behavior. Juvenile sex offenders frequently engage in nonsexual criminal and antisocial behavior (Fehrenbach et al., 1986; Ryan et al., 1996). A national survey found that most of the 80 juveniles who disclosed sexually assaultive behavior had previously committed a nonsexual aggravated assault (Elliot, as cited in Weinrott, 1996).

Child Maltreatment Histories

The childhood experience of sexual abuse has been associated with juvenile sex offending (Fehrenbach et al., 1986; Kahn and Chambers, 1991; Kobayashi et al., 1995). Childhood experiences of being physically abused, being neglected, and witnessing family violence also have been independently associated with sexual violence in juvenile offenders (Kobayashi et al., 1995; Ryan et al., 1996). The abusive experiences of juvenile sex offenders, however, have not consistently been found to differ significantly from those of other juvenile offenders (Lewis, Shanok, and Pincus, as cited in Knight and Prentky, 1993; Spaccarelli et al., 1997). Research suggests that the role of child maltreatment in the etiology of sex offending is quite complex (Prentky et al., 2000).

Social and Interpersonal Skills and Relationships

Family factors. Factors such as family instability, disorganization, and violence have been found to be prevalent among juveniles who engage in sexually abusive behavior (Bagley and Shewchuk-Dann, 1991; Miner, Siekert, and Ackland, 1997; Morenz and Becker, 1995). Various studies (e.g., Kahn and Chambers, 1991; Fehrenbach et al., 1986; Smith and Israel, 1987) suggest that many juvenile sex offenders have experienced physical and/or emotional separations from one or both of their parents.

Social skills and relationships. Research repeatedly documents that juveniles with sexual behavior problems have significant deficits in social competence (Becker, 1990; Knight and Prentky, 1993). Inadequate social skills, poor peer relationships, and social isolation are among the difficulties identified in these juveniles (Fehrenbach et al., 1986; Katz, 1990; Miner and Crimmins, 1995).

Sexual Knowledge and Experiences

Sexual histories and beliefs. Research suggests that adolescent sex offenders generally have had previous consenting sexual experiences (Becker, Kaplan, Cunningham-Rathner, and Kavoussi, as cited in Knight and Prentky, 1993; Groth and Longo, as cited in Knight and Prentky, 1993; Ryan et al., 1996). Research also suggests that sometimes their previous experiences exceed those of juveniles who have not committed sex offenses (McCord, McCord, and Venden, as cited in Knight and Prentky, 1993). Prior experiences with sexual dysfunction, most commonly impotence or premature ejaculation, have also been reported in juvenile sex offenders (Longo, as cited in Knight and Prentky, 1993). A study of 1,600 juvenile sex offenders from 30 States (Ryan et al., 1996) found that only about one-third of the juveniles perceived sex as a way to demonstrate love or caring for another person; others perceived sex as a way to feel power and control (23.5 percent), to dissipate anger (9.4 percent), or to hurt, degrade, or punish (8.4 percent).

Deviant sexual arousal. Studies of male college students and adult sex offenders have shown that deviant sexual arousal is strongly associated with sexually coercive behavior (Barbaree and Marshall, as cited in Hunter and Becker, 1994; Earls and Quinsey, as cited in Hunter and Becker, 1994; Prentky and Knight, as cited in Knight and Prentky, 1993). Controlled studies of deviant sexual arousal in juvenile sex offenders are lacking. Two studies (Schram, Milloy, and Rowe, 1991; Kahn and Chambers, 1991) reported associations between sexual reoffending in juveniles and deviant sexual arousal, but both studies relied on clinical judgments rather than objective methods to identify deviant arousal.

Pornography. Investigations into the role of pornography in juvenile sex offending are limited in number. One study (Becker and Stein, as cited in Hunter and Becker, 1994) found that only 11 percent of the juvenile sex offenders studied said they did not use sexually explicit materials. Another study (Wieckowski et al., 1998) found that exposure to pornographic material at a young age was common in a sample of 30 male juveniles who had committed sex offenses. A comparative study (Ford and Linney, as cited in Becker and Hunter, 1997) found that 42 percent of juvenile sex offenders, compared with 29 percent of juvenile violent offenders (whose offenses were nonsexual) and status offenders, had been exposed to hardcore, sexually explicit magazines.

Academic and Cognitive Functioning

Academic performance. Studies typically report that as a group, juveniles who sexually offended experienced academic difficulties (Fehrenbach et al., 1986; Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997; Pierce and Pierce, as cited in Bourke and Donohue, 1996). One study (O'Brien, as cited in Ferrara and McDonald, 1996), however, found that 32 percent of a sample of male juvenile sex offenders had above-average academic performance.

Intellectual and cognitive impairments. Research that focuses on the intellectual and cognitive functioning of juveniles who have committed sex offenses is limited. Existing studies, however, suggest that intellectual and cognitive impairments are factors that should be addressed (Awad, Saunders, and Levene, as cited in Knight and Prentky, 1993; McCurry et al., 1998). Based on their review of the literature, Ferrara and McDonald (1996) concluded that between one-quarter and one-third of juvenile sex offenders have some form of neurological impairment.

Cognitive distortions and attributions. Knight and Prentky (1993) pointed out that some factors observed in abused children (e.g., reduced empathy, inability to recognize appropriate emotions in others, and inability to take another person's perspective) may have relevance for juvenile sex offenders who have been maltreated. This observation is consistent with research indicating that cognitive distortions, such as blaming the victim, are associated with sexual reoffending in juveniles (Kahn and Chambers, 1991; Schram, Milloy, and Rowe, 1991).

Mental Health Issues

Symptoms and disorders. Conduct disorder diagnoses and antisocial traits frequently have been observed in populations of juveniles who have sexually offended (Kavoussi, Kaplan, and Becker, 1988; Miner, Siekert, and Ackland, 1997). Studies also have described other behavioral and personality characteristics in juveniles who have sexually offended, such as impulse control problems and lifestyle impulsivity (Prentky and Knight, as cited in Prentky et al., 2000; Smith, Monastersky, and Deisher, as cited in Prentky et al., 2000). Carpenter, Peed, and Eastman (1995) found that juvenile sex offenders whose victims were younger children had higher scores on the Schizoid, Avoidant, and Dependent scales of the Millon Clinical Multiaxial Inventory (MCMI) than those whose victims were their age peers. Studies also have found higher rates of depression in juveniles who have sexually offended than in the general juvenile population (Becker et al., as cited in Becker and Hunter, 1997; Kaplan, Hong, and Weinhold, as cited in Becker and Hunter, 1997). Few studies of adolescents and children with sexual behavior problems report major psychopathology in the subjects and their families (Becker, as cited in Ferrara and McDonald, 1996; Johnson, as cited in Ferrara and McDonald, 1996).

Substance abuse. Studies vary widely on the importance of substance abuse as a factor in sex offending among juveniles. Lightfoot and Barbaree (1993) reported that rates at which juvenile sex offenders were found to be under the influence of drugs or alcohol at the time they committed their offenses ranged from 3.4 percent to 72 percent. Although substance abuse has been identified as a problem for many juveniles who have sexually offended (Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997), the role of substance abuse in sex offending remains unclear. Lightfoot and Barbaree pointed out that assessments of juvenile sex offenders should differentiate substance abuse problems from "normative" experimentation that is part of the developmental process. It appears that evidence is insufficient to identify substance abuse as a causative factor in the development of sexually abusive behavior, although substance abuse has a disinhibiting potential and, if present, may require intervention.

Types and Classifications

Types and Classifications of Male Adolescents Who Have Committed Sex Offenses

Although a variety of characteristics have been identified among juveniles who have sexually offended, few studies have attempted to classify these juveniles according to their similarities and differences. O'Brien and Bera (as cited in Weinrott, 1996) defined seven categories of juvenile sex offenders: naive experimenters, undersocialized child exploiters, sexual aggressives, sexual compulsives, disturbed impulsives, group influenced, and pseudosocialized. Graves (as cited in Weinrott, 1996) suggested three typologies: pedophilic, sexual

assault, and undifferentiated. Prentky et al. (2000) used six categories: child molesters, rapists, sexually reactive children, fondlers, paraphilic offenders, and unclassifiable. Weinrott (1998a) suggested four general types: juvenile delinquents in general, those who have deviant arousal, those who are psychopathic offenders, and those who fit none of these categories and may only require limited intervention. More research that differentiates juvenile sex offenders according to their various behavior patterns, cognitive and emotional functioning, and other relevant factors is needed to determine and apply appropriate and effective treatment strategies.

Sibling Incest

Few reports have specifically addressed issues pertaining to sibling incest. Araji (1997) noted that although sibling incest appears to be quite prevalent, often it is underreported and ignored. O'Brien (1991) compared sibling sex offenders with juvenile sex offenders whose victims were either children outside the family, adults, peers, or a mix of categories and found that the sibling offenders had more serious offending histories, were less likely to receive court-ordered treatment, and differed from the nonsibling offenders on several measures (including family factors such as presence of dysfunction and physical abuse). A study of inner-city minority juveniles (Becker et al., 1986), however, found that 9 of 22 sibling offenders also evidenced nonsibling paraphilic behavior. Bonner and Chaffin (1998) asserted that most interventions designed to address sibling sexual behavior assume a victim-perpetrator model but that such a model may not always be appropriate.

Girls Who Have Committed Sex Offenses

Incidence. Research on girls who have committed sex offenses has been relatively rare, and existing studies have been limited by small sample sizes and other factors. In their review of the literature, Lane and Lobanov-Rostovsky (1997) found that females represented 5–8 percent of juvenile sex offenders in three statewide incidence studies conducted in the 1980's. More recent studies, however, found a higher incidence of sex offending by young girls (English and Ray, as cited in Araji, 1997; Johnson, as cited in Lane and Lobanov-Rostovsky, 1997; Gray et al., 1997). The incidence of sex offending may be underestimated for female juveniles even more than for males, perhaps because of a societal reluctance (and even a reluctance among professionals) to acknowledge that girls are capable of committing such offenses (Travin, Cullen, and Protter, 1990).

Characteristics of female offenders and their offenses. Ray and English (1995) compared girls and boys in a sample of juveniles who were described as sexually aggressive. They found the girls tended to be younger than the boys and were less likely to have perpetrated acts of rape. The girls were more likely to be victims of sexual abuse, and more girls than boys had experienced multiple types of abuse. Fehrenbach and Monastersky (as cited in Bumby and Bumby, 1997) found that, in their sample, most adolescent girls who sexually victimized young children did so while engaged in a childcare situation. Studies of girls in inpatient settings (Bumby and Bumby, 1997; Hunter et al., as cited in Bumby and Bumby, 1997), although limited by small sample size, suggest that factors such as depression, suicidal ideation, anxiety, poor self-concept, and childhood sexual victimization are relevant for girls who commit sex offenses. In perhaps the largest study to date, Mathews, Hunter, and Vuz (1997) compared 67 girls and 70 boys who had histories of sex offending and found meaningful similarities and differences: the girls' offending behaviors were similar to the boys' in terms of types of offenses committed, and both tended to victimize young children of the opposite gender; but girls typically had more severe victimization experiences themselves.

Young Children Who Have Committed Sex Offenses

Incidence. In the 1980's, after the problem of adolescent sex offending gained attention, similar behaviors in preadolescent and younger children also were recognized. Recent surveys suggest an increase in the rate of

preadolescent children who evidence sexually abusive behaviors. This apparent increase may reflect a greater awareness of the problem. In an extensive review of the literature pertaining to children who have been sexually aggressive, Araji (1997) stressed that research in this area is in its infancy and noted that many findings are simply clinical observations.

Individual characteristics. Available studies (Araji, 1997) have reported sexual aggression in children as young as 3 and 4; the most common age of onset appears to be between 6 and 9. Girls were represented in much greater numbers among these children than among adolescents who have abused, and these girls often engaged in behaviors that were just as aggressive as the boys' actions. Victims of preadolescents tended to be very young (averaging between ages 4 and 7), most often were female, and typically were siblings, friends, or acquaintances. Preadolescents who have sexually abused have been found to have high rates of sexual victimization experiences (Johnson, as cited in Araji, 1997; Friedrich and Luecke, as cited in Araji, 1997; Araji, Jache, Tyrrell, and Field, as cited in Araji, 1997; Araji, Jache, Pfeiffer, and Smith, as cited in Araji, 1997; Bonner, Walker, and Berliner, as cited in Araji, 1997; Pithers et al., 1998b) and significantly higher rates of abuse and neglect victimization experiences than those found among their adolescent counterparts (English and Ray, as cited in Araji, 1997). These preadolescents have also been found to have frequent academic and learning difficulties and impaired peer relationships (Friedrich and Luecke, as cited in Araji, 1997; Pithers and Gray, as cited in Araji, 1997).

Family characteristics. Studies described by Araji (1997) also found that families of preadolescents who have sexually abused tended to be dysfunctional. Araji concluded, "The evidence . . . points to family interactions as a primary source of the problem" (p. 87). The importance of family factors is supported by research conducted by Pithers et al. (1998a) concerning the caregivers of 72 children with sexual behavior problems. The families of these children tended to be characterized by high levels of poverty, single parenting, sexual abuse, domestic violence, and parenting stress.

Comparative studies of preadolescents and adolescents who have committed sex offenses. English and Ray (as cited in Araji, 1997) studied 271 juveniles who sexually offended by comparing the preadolescents with the adolescents. Although the researchers found many similarities between the groups (e.g., previous aggressive behavior, psychiatric problems, and levels of intellectual functioning), there were significant differences in the nature of their offenses and in their attitudes about the offenses. The adolescents had higher rates of depressive symptoms and suicidal gestures, perhaps (as Araji suggested) reflecting developmental differences between the groups. Both groups had a moderate to moderately high number of risk factors associated with repeat offending; risk factors included various characteristics of the juveniles, their families and environments, and their victims. The preadolescent children's families, however, evidenced significantly more problems, and the younger children also had significantly higher levels of social isolation and current life stresses.

Types and classifications. Young children who have sexual behavior problems are a heterogeneous group. Descriptions of these children typically differentiate normative sexual behavior from a continuum of progressively excessive and abusive sexual behaviors (Araji, 1997; Johnson, 1991). For example, Johnson (1991) classified these children into four groups: normal sexual exploration, sexually reactive, extensive mutual sexual behaviors, and child perpetrators. Araji (1997) conceptualized a subgroup of children—"sexually aggressive children"—who are comparable to children in Johnson's child perpetrators group and are at the extreme end of a childhood sexual behavior continuum. In a study of 127 children ages 6–12 who had evidenced sexual behavior problems, Pithers et al. (1998b) identified five subtypes: sexually aggressive, nonsymptomatic, highly traumatized, abusive reactive, and rule breaker. (The Pithers et al. study appears to be the first attempt to develop empirically derived and clinically relevant classifications of these children.) Longitudinal studies following these children over time are lacking; therefore, it is not known whether childhood sexual behavior problems continue or, more accurately, which children persist in their sexual misconduct in adolescence and adulthood.

Juveniles With Developmental Disabilities and Mental Retardation Who Have Committed Sex Offenses

In one of the few studies focusing on adolescent sex offenders with mental retardation, Gilby, Wolf, and Goldberg (1989) found that the frequency of sexual behavior problems among these juveniles did not differ significantly from the frequency among juveniles with normal (defined by the authors as borderline or higher) intellectual functioning. The researchers did, however, document some differences in the sexual behavior patterns of the two groups: for example, the juveniles with mental retardation had a higher rate of sexual assaults against peers and were less likely to know their victims. Although this study is informative, additional research is needed to determine whether the findings can be generalized to other juveniles with mental retardation who have committed sex offenses.

Juveniles Who Have Committed Sex Offenses Versus Other Types of Offenses

Although research is limited, available studies suggest that juveniles who commit sex offenses and juveniles who commit other types of offenses share many characteristics (e.g., Miner and Crimmins, 1995). Most recently, a study of chronic delinquents (Spaccarelli et al., 1997) found no differences on any of the measured variables between 50 sex offenders and 106 juveniles arrested for violent but nonsexual offenses.

Assessment

Clinical Assessment

In view of the heterogeneous nature of juveniles who have sexually offended, comprehensive assessments of individuals are needed to facilitate treatment and intervention strategies. These include assessment of each juvenile's needs (psychological, social, cognitive, and medical), family relationships, risk factors, and risk management possibilities.

Gathering multiple sources of information. Parents or guardians of juveniles should be involved in the assessment and in the treatment process (Morenz and Becker, 1995). Their informed consent should be obtained, and they should be clearly informed of the limits of confidentiality (Becker and Hunter, 1997). Comprehensive assessments should include clinical interviews with the juveniles and family members, a psychological assessment, and, in certain cases (according to some), phallometric assessment (Bonner et al., 1998; Morenz and Becker, 1995; Becker and Kaplan, 1993). Evaluators should review victim statements, juvenile court records, mental health reports, and school records as part of their assessment (Becker and Hunter, 1997).

Using psychological tests. Psychological tests have been described as adding a "critical dimension" to comprehensive evaluations of juveniles who have sexually offended (Kraemer, Spielman, and Salisbury, 1995). Bourke and Donohue (1996) observed that studies consistently reveal the heterogeneity of these juveniles and cited a wide range of coexisting psychological disorders to emphasize the importance of using comprehensive, standardized methods of assessment. Kraemer, Spielman, and Salisbury (1995) described four primary domains that require assessment: intellectual and neurological, personality functioning and psychopathology, behavioral, and sexual deviance.

Assessing deviant sexual arousal. To adequately assess individuals who appear to evidence deviant arousal, Weinrott (1998a) stressed the importance of using direct measurement of an individual's sexual arousal, through phallometric assessment. Others, however, have discussed potential ethical concerns related to using phallometric assessment with juveniles (Bourke and Donohue, 1996; Cellini, 1995). Weinrott (1998a) suggested ways of addressing these issues. Another psychophysiological assessment measure used with juveniles who have sexually offended is the Abel Assessment for Interest in Paraphilias (Abel Screening, Inc., 1996).

The Abel Assessment is significantly less invasive than phallometric assessment, and research conducted by the test developers has shown good results. However, an independent study of the Abel Assessment's reliability and validity raised questions about the use of this assessment approach with juveniles at this time (Smith and Fischer, 1999). The Abel Assessment is relatively new, and additional independent, published research is needed.

Substance abuse assessment. Assessment of a juvenile who has committed a sex offense needs to determine whether the juvenile has a substance abuse problem and, if so, whether it is a risk factor for that juvenile's sex offending. Researchers and clinicians have emphasized the importance of using valid and reliable assessment tools to screen for substance abuse problems (Becker and Hunter, 1997; Lightfoot and Barbaree, 1993).

Polygraph tests. Although controversial, the use of polygraph tests in treatment programs for juveniles who have been sexually abusive is increasing (National Adolescent Perpetrator Network [NAPN], 1993). The polygraph is used to facilitate more complete disclosures of sexually abusive behaviors and to monitor compliance with treatment. The National Task Force on Juvenile Sexual Offending has emphasized that polygraphs must be administered on a voluntary basis and with informed consent (NAPN, 1993). Research regarding the reliability and validity of the polygraph for assessing juveniles who have committed sex offenses is very limited (Hunter and Lexier, 1998), and some researchers have seriously questioned its validity (Cross and Saxe, as cited in Bonner et al., 1998; Saxe, Dougherty, and Cross, as cited in Bonner et al., 1998).

Risk Assessment

Few empirical studies have investigated sexual reoffense rates among juveniles or risk factors associated with recidivism. Two retrospective studies that investigated the frequency of offenses prior to the referral offense found relatively high offense rates (Awad and Saunders, 1991; Fehrenbach et al., 1986).

Rates of recidivism. The results of research investigating recidivism after juveniles were referred for sex offenses typically reveal relatively low rates of sexual recidivism (8 to 14 percent) (Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997; Rasmussen, 1999; Schram, Milloy, and Rowe, 1991; Sipe, Jensen, and Everett, 1998; Smith and Monastersky, 1986). The studies also find higher rates of nonsexual recidivism (16 to 54 percent). Methodological variations clearly influence recidivism rates (Prentky et al., 1997). Nevertheless, in an extensive review of studies investigating recidivism rates among juvenile sex offenders, Weinrott (1996, p. 67) noted: "What virtually all of the studies show, contrary to popular opinion, is that relatively few [juvenile sex offenders] are charged with a subsequent sex crime."

Factors associated with recidivism. Various studies have described characteristics identified in juveniles who have sexually offended. However, Weinrott (1998b) reported that very few characteristics have actually been empirically associated with sexual recidivism. He noted that these characteristics include the following: psychopathy, deviant arousal, cognitive distortions, truancy, a prior (known) sex offense, blaming the victim, and use of threat/force. Weinrott also reported that, contrary to common belief, factors such as social skills deficits, lack of empathy, or denial of offense or sexual intent either have not been empirically associated with sexual recidivism or have simply not been investigated. (This is not to say that interventions designed to address such factors, such as efforts to reduce social skills deficits or educate offenders about victim impact, are not effective in reducing sexual recidivism, only that there is no empirical evidence indicating they are effective.)

Prediction of recidivism. Chaffin and Bonner (1998) pointed out that there are no true experimental studies comparing untreated and treated juvenile sex offenders and no prospective studies evaluating risk factors or the natural course of sexual offending. Studies suggest that treatment providers may tend to overpredict sexual recidivism rather than risk the dire consequences associated with failing to predict recidivism that comes to pass. Factors limiting the accuracy of recidivism predictions include the relative infrequency and hidden

nature of sex offending, too-short followup periods, and insufficient or inadequate information relevant for decisionmaking. To enhance predictive accuracy, professionals should balance historical and actuarial information with clinical and situational information (Smith and Monastersky, 1986; Webster et al., 1997). Prentky et al. (2000) have developed and conducted initial testing of an actuarial risk assessment schedule designed to evaluate the risk of reoffending among juvenile sex offenders. As Epps (1994) noted, potential problems in using risk assessment tools to predict juvenile sex offenders' likelihood of reoffending include difficulties in gathering reliable and valid information upon which to base such instruments.

Treatment

The National Task Force on Juvenile Sexual Offending articulated a set of assumptions intended to reflect the current thinking relevant to a comprehensive systems response to juveniles who have sexually offended (NAPN, 1993). These assumptions are summarized below:

- Following a full assessment of the juvenile's risk factors and needs, individualized and developmentally sensitive interventions are required.
- Individualized treatment plans should be designed and periodically reassessed and revised. Plans should specify treatment needs, treatment objectives, and required interventions.
- Treatment should be provided in the least restrictive environment necessary for community protection. Treatment efforts also should involve the least intrusive methods that can be expected to accomplish treatment objectives.
- Written progress reports should be issued to the agency that has mandated treatment and should be discussed with the juvenile and parents. Progress "must be based on specific measurable objectives, observable changes, and demonstrated ability to apply changes in current situations" (NAPN, 1993, p. 53).
- Although adequate outcome data are lacking, NAPN (1993) suggests that satisfactory treatment will require a minimum of 12 to 24 months.

Some individual States also have worked to develop appropriate protocols and standards for effective interventions with juveniles who have committed sex offenses. Treatment programs for these juveniles have proliferated during the past decade, increasing from approximately 20 in 1982 (NAPN, 1988) to more than 680 in 1994 (Freeman-Longo et al., 1994).

Continuum of Care Models

To adequately address both the needs of individual juveniles who have committed sex offenses and the needs of the community, a continuum of care is recommended (Bengis, 1997; NAPN, 1993). Offering a range of interventions and placement options makes it possible to provide cost-effective interventions while placing paramount importance on community safety. Suggested components of such a continuum have been described in the *Oregon Report on Juvenile Sex Offenders* (Avalon Associates, 1986) and also by Bengis (1997) and the Utah Task Force of the Utah Network on Juveniles Offending Sexually (1996). Bengis pointed out that at different points during their treatment, juveniles may require different levels of supervision and treatment intensity. Bengis also stressed that to be most effective, the components of the continuum should have consistent treatment philosophies and approaches and should provide stability in treatment providers as the juvenile moves along the continuum.

Treatment Approaches

Overview. Primary goals in the treatment of juveniles who have sexually offended have been defined variously as community safety (NAPN, 1993), helping juveniles gain control over their abusive behaviors and increase their prosocial interactions (Cellini, 1995), and preventing further victimization, halting development of additional psychosexual problems, and helping juveniles develop age-appropriate relationships (Becker and Hunter, 1997). To accomplish these goals, highly structured interventions are recommended (Morenz and Becker, 1995). Treatment approaches include individual, group, and family interventions. Although group therapy often is described as the treatment of choice and cotherapy teams also are recommended (NAPN, 1993), empirical evidence of the superiority of these approaches is lacking. Advantages and disadvantages of these approaches have been described elsewhere (e.g., Marshall and Barbaree, 1990; Henggeler, Melton, and Smith, 1992). The first step in treatment typically involves helping the juvenile accept responsibility for his or her behavior (Becker and Hunter, 1997). Recommended treatment content areas typically include sex education, correction of cognitive distortions (cognitive restructuring), empathy training, clarification of values concerning abusive versus nonabusive sexual behavior, anger management, strategies to enhance impulse control and facilitate good judgment, social skills training, reduction of deviant arousal, and relapse prevention (Becker and Hunter, 1997; Hunter and Figueredo, 1999; NAPN, 1993). Many other relevant interventions also have been documented. Leaders in the treatment field have argued that programs designed to focus exclusively on sex-offending behaviors are of limited value and have recommended a more holistic approach (Goocher, 1994).

Addressing deviant arousal. Most programs that address deviant arousal do so through covert sensitization, a treatment approach that teaches juveniles to interrupt thoughts associated with sex offending by thinking of negative consequences associated with abusive behavior (Becker and Kaplan, 1993; Freeman-Longo et al., 1994). Other techniques include various forms of behavioral conditioning and are much more invasive and aversive. Such techniques raise concerns regarding practicality, effectiveness, and/or ethics. Vicarious sensitization (VS) is a relatively new technique that involves exposing juveniles to audiotaped crime scenarios designed to stimulate arousal and then immediately showing a video that portrays the negative consequences of sexually abusive behavior. Preliminary research findings suggest VS may be an effective approach for reducing deviant arousal in juveniles who are sexually aroused by prepubescent children (Weinrott, Riggan, and Frothingham, 1997).

Involving families. Rasmussen (1999) argued that adequate family support can help reduce recidivism and that treatment programs that involve families are likely to be more effective than others that do not. As Gray and Pithers (1993) observed, however, families vary in terms of their motivation and ability to effectively facilitate their child's treatment. Gray and Pithers described strategies that can engage the cooperation of family members and reported approaches that parents found useful.

Using a relapse prevention model. Gray and Pithers (1993) applied relapse prevention to the treatment and supervision of children and adolescents with sexual behavior problems. This technique requires that juveniles learn to identify factors associated with an increased risk of sex offending and use strategies to avoid high-risk situations or effectively manage them when they occur. When relapse prevention is applied to children, greater emphasis is placed on external supervision to prevent further victimization. Empirical studies investigating the effectiveness of this approach are lacking.

Summary. Some of the interventions described above appear appropriate for some juveniles who have committed sex offenses, but others do not. Furthermore, many of the target areas described are relevant not only for sex offenders but also for juveniles who commit other types of offenses. In view of the many studies identifying general delinquency and antisocial attitudes and behavior among juveniles who exhibit sexual behavior problems, Weinrott (1998a) suggested that relevant empirically based treatment interventions for juvenile delinquents be used with those who have committed sex offenses.

Research on Treatment Efficacy

Specialized treatment for juveniles who have committed sex offenses. Programs specifically designed for juveniles who have sexually offended have proliferated, but evaluation of these specialized approaches has been limited. For example, most programs have learning about the "sexual assault cycle" at their core, but despite the fact that the sexual assault cycle has been in use in sex offender treatment for nearly 20 years, the model has not been empirically validated (Weinrott, 1996). Chaffin and Bonner (1998) cautioned against the "conviction" that those working in the field have found the right approach and summarized the beliefs about sex-offense-specific interventions that may be included in such "dogma." Chaffin and Bonner (1998) and Weinrott (1996) have observed that it currently is not possible to say whether one type of treatment is better than another, with the possible exception that delinquency-focused multisystemic treatment appears to be more effective than individual counseling with juveniles who have committed sex offenses. A study by Lab, Shields, and Schondel (1993) appears to raise questions about the efficacy of specialized treatment for juveniles who have committed sex offenses. A study by Kimball and Guarino-Ghezzi (1996), however, found that juvenile sex offenders placed in sex-offense-specific treatment demonstrated more positive attitudes and greater skill acquisition than those in nonspecific treatment. (Juveniles in sex-offense-specific treatment, however, received more intensive and varied interventions than those in non-offense-specific treatment.)

Treatment for juveniles who are delinquent. Research has been conducted to assess the effectiveness of interventions with juveniles who commit various types of offenses, not just sex offenses. Because general delinquency and antisocial attitudes and behavior are frequently found in juveniles who have committed sex offenses, these treatment approaches may be relevant and effective with these juveniles. Izzo and Ross (1990) conducted a meta-analysis of rehabilitation programs designed for all juvenile delinquents, not just those who have committed sex offenses. Their findings suggest that programs based on cognitive therapy were twice as effective as those using other approaches. More recently, Lipsey and Wilson (1998) conducted a meta-analysis of 200 experimental or quasi-experimental studies to assess the effectiveness of treatment interventions used with juvenile offenders. They found that among noninstitutionalized juveniles, treatments that focused on interpersonal skills and used behavioral programs consistently yielded positive effects. Other interventions that have been validated with chronic delinquents, such as multisystemic therapy and multidimensional treatment foster care, also are promising approaches for juveniles who have committed sex offenses (Borduin et al., 1990; Chamberlain and Reid, 1998; Swenson et al., 1998).

Attrition from sex-offense-specific treatment. Several studies of sex offender treatment programs have demonstrated high rates of treatment dropouts (Becker, 1990; Hunter and Figueredo, 1999; Kraemer, Salisbury, and Spielman, 1998; Rasmussen, 1999; Schram, Milloy, and Rowe, 1991). High rates of treatment attrition are extremely important. A study of juvenile sex offenders (Hunter and Figueredo, 1999) and several studies of adult offenders (e.g., Hanson and Buissière, 1998) suggest that failing to complete treatment is associated with higher rates of recidivism for both sex offenses and other types of offenses.

Treatment Setting

Segregating versus integrating juveniles who have committed sex offenses. Historically, treating juveniles who have committed sex offenses in a setting specifically designed for sex offenders has been considered "optimal" (Morenz and Becker, 1995). The literature, however, indicates that the effectiveness of this approach has not been proven. In fact, some studies suggest that other approaches may be more beneficial. Milloy (1994) indicated that no controlled studies have been published investigating the effect of segregating juvenile sex offenders from the general delinquent population. Whether juveniles who have been sexually abusive should be grouped with juveniles who have committed nonsexual offenses or with juveniles who have other behavioral problems is a complex issue. Arguments exist both for and against the use of segregated treatment units. In the meantime, the importance of individualized assessment and treatment planning cannot be overemphasized.

Facilitating safety in residential treatment settings. The issue of community safety exists regardless of whether a juvenile sex offender remains in the community or is placed in a segregated or unsegregated residential facility. NAPN (1993) provided specific recommendations to facilitate safety in residential treatment facilities.

Special Populations

Treatment of young and preadolescent children with sexual behavior problems. Gray and Pithers (1993) suggested that sexually abusive behaviors in children might be most effectively addressed by targeting risk factors that predispose a child to sexual behavior problems or that precipitate or perpetuate the problems. Araji (1997) described 10 treatment programs and practices for children with sexual behavior problems. All of the programs reviewed by Araji included cognitive-behavioral approaches; treatment modalities involved individual, group, pair, and family therapy (most providers appeared to prefer group therapies). Important factors when intervening with children who have been sexually abusive include addressing developmental issues and involving parents and other caregivers. As noted above, Pithers et al. (1998b) identified five subtypes of children with sexual behavior problems. Their investigations also revealed some differences in how children in various subtype classifications responded to different types of treatment.

Treatment of juveniles with cognitive or developmental disabilities. Special interventions may be necessary for juveniles with intellectual and cognitive impairments. For example, individuals with learning difficulties may not respond well to therapies (such as cognitive-behavioral approaches) that resemble their negative experiences in the classroom. A review of the literature (Stermac and Sheridan, 1993) found a dearth of research on treatment of adults and adolescents with developmental disabilities. Most studies have focused on adult offenders and have stressed behaviorally oriented interventions, and most interventions involving adolescents with developmental disabilities who have committed sex offenses have used approaches modified from adult treatment programs. Langevin, Marentette, and Rosati (1996) urged treatment professionals to reach out to these juveniles and suggested steps for doing so. Ferrara and McDonald (1996) provided a detailed discussion of treatment strategies and techniques that may be useful.

Training and Qualifications of Treatment Providers

Individuals providing treatment for juveniles with sexual behavior problems must be personally and professionally qualified (Association for the Treatment of Sexual Abusers, 1997a; NAPN, 1993). Personal qualifications include being emotionally healthy, having respect for oneself and others, using good listening skills, and having the ability to empathize. Professional qualifications include relevant education, training, and experience. Treatment providers should receive appropriate training before they begin their work and thereafter on a continuing basis. Working with juveniles who have sexual behavior problems is a challenging job. As NAPN (1993) observed, "Systems must be aware of potential emotional/psychological impacts on providers and take steps to protect against or counter negative effects" (p. 46).

Program Evaluation

Adequate program evaluation involves at least two primary approaches: (1) implementation research to ensure that the components necessary for effective treatment exist and are implemented and (2) outcome research to determine whether the interventions have been effective. Although the importance of program evaluation cannot be overemphasized, evaluations of sex offender treatment programs have been few, and those that have been conducted often have had inadequate designs (Camp and Thyer, 1993). Most outcome studies have used recidivism rates to assess treatment effectiveness, but several problems (generally low rates of recidivism, short followup periods, variability in outcome measures, and other methodological problems) limit the usefulness of

this approach. Other approaches to assessing treatment effectiveness are required. Two studies have used self-report measures to evaluate treatment effectiveness (Hains et al., as cited in Camp and Thyer, 1993; Miner, Siekert, and Ackland, 1997). Laben, Dodd, and Sneed (1991) used goal attainment theory to develop measurable outcomes in an inpatient juvenile sex offender treatment program. This approach required treatment providers and clients to establish mutual goals through a process of bargaining, negotiating, identifying commonalties, and defining measurable outcomes.

Conclusions

The findings of this literature review indicate that juveniles who have committed sex offenses are a heterogeneous group who, like all juveniles, have developmental needs, but who also have special needs and present special risks related to their abusive behaviors. Existing studies suggest that a substantial proportion of these juveniles desist from committing sex offenses following the initial disclosed offense and intervention.

The literature clearly supports the importance of interventions that are tailored to the individual juvenile. Risk management strategies likely to be most effective are those that address the needs underlying a juvenile's behavior and make the most of the juvenile's existing strengths and positive supports. Although efficacy has not been established for many sex offender interventions considered standard and required, there are a wide range of interventions with more of an empirical basis, particularly within the juvenile delinquency field (such as multisystemic therapy), that may be effective. It also should be remembered that some juveniles may require minimal interventions once their sex offending has been disclosed. An additional—and important—caution is that treatment efforts should not be harmful.

Lastly, it should be remembered that although the goal when working with juveniles who have committed sex offenses is to help them stop their abusive behaviors, they are children and adolescents first. They are young people who have committed offenses and who deserve care and attention.

Introduction

Sexual abuse is widely recognized as a significant problem in society. Juveniles[1] who commit sex offenses have victimized many people. Federal Bureau of Investigation data (as cited in Sipe, Jensen, and Everett, 1998) indicate that in 1995, 15.8 percent of arrests for forcible rape and 17 percent of arrests for all other sex offenses involved persons under 18 years old. Furthermore, Becker, Cunningham-Rouleau, and Kaplan (as cited in Prentky et al., 2000) reported that 79 percent of their sample of juvenile sex offenders had been arrested for a prior sex offense. Similarly, Groth (as cited in Prentky et al., 2000) found that nearly 75 percent of his sample of juvenile sex offenders had committed a prior sexual assault.

Studies of adult sex offenders (who were assured that the information they provided would remain confidential) also support the conclusion that sexual abuse by juveniles is a serious problem. This research suggests that approximately half of these individuals began their sexually abusive behavior before adulthood (Abel, Mittelman, and Becker, 1985; Groth, Longo, and McFadin, 1982; Saylor, as cited in Smith and Monastersky, 1986). Studies of juveniles and adults who committed sex offenses as juveniles indicate that juvenile sex offending includes a wide range of sexual misconduct. Offenses included noncontact sexual behaviors (such as exhibitionism and voyeurism), child molestation, and rape (Abel, Osborn, and Twigg, 1993; Righthand, Hennings, and Wigley, 1989). Research has shown that the sexual behavior problems exhibited by these juveniles are "not simply isolated incidents involving normally developing adolescents" (Fehrenbach et al., 1986, p. 231).

The scope of the problem may be underestimated because juvenile sex offenders who become known to the system may represent only a small proportion of juveniles who have committed such offenses. Knight and Prentky (1993) found that only 37 percent of the adult sex offenders in their sample had official records documenting juvenile sex offending histories. In contrast, when these subjects completed a computer-generated questionnaire and were assured that their responses would remain confidential, 55 percent acknowledged engaging in sexually abusive behavior as juveniles.

The importance of early intervention with juveniles who evidence sexual behavior problems cannot be overstated. As noted by Abel, Osborn, and Twigg (1993)—

> If an individual begins to engage in such behaviors and is not subject to intervention and/or negative consequences for such actions, he will be reinforced by the innate positive reinforcers of the sexual act. These inherent positive reinforcers include, but are not limited to, the pleasure of orgasm, the pleasure of stress reduction, and the feeling of power the individual may feel over another person. (p. 15)

[1] Historically, most studies have focused on males, although some, particularly those that describe the characteristics of juveniles who commit sex offenses, have also included females. In this review, among the studies specifying that both males and females were included (or publications citing such studies) are the following: Becker and Hunter, 1997; Bourke and Donohue, 1996; Bumby and Bumby, 1997; English and Ray (as cited in Araji, 1997); Fehrenbach et al., 1986; Fehrenbach and Monastersky (as cited in Bumby and Bumby, 1997); Hunter, Lexier, Goodwin, Browne, and Dennis (as cited in Bumby and Bumby, 1997); Johnson (as cited in Lane and Lobanov-Rostovsky, 1997); Kahn and Chambers, 1991; Gray et al., 1997; Lane and Lobanov-Rostovsky, 1997; Mathews, Hunter, and Vuz, 1997; McCurry et al., 1998; Morenz and Becker, 1995; Ray and English, 1995; Righthand, Hennings, and Wigley, 1989; Ryan et al., 1996; Smith and Israel, 1987; and Weinrott, 1996.

The costs of sex offending are substantial for victims and society and for the young offenders and their families. In addition to the human costs in terms of emotional and physical anguish and suffering, staggering financial costs are incurred as a result of child welfare and juvenile and criminal justice system involvement, therapeutic intervention, and so forth (Prentky and Burgess, 1990). To minimize these costs, timely and appropriate interventions are needed.

A review of the professional literature suggests that developers of programs to meet the perceived needs of these young offenders frequently have applied knowledge and interventions designed for adult offenders without considering the developmental issues and needs unique to juveniles. Only recently have a growing number of professionals pointed to the empirical literature to emphasize that, especially when it comes to juveniles, research has not supported the notion that "once a sex offender, always a sex offender" (Association for the Treatment of Sexual Abusers, 1997b; Becker, 1998). The longitudinal research necessary to conclusively support such a hypothesis has not been conducted (Becker, 1998).

In addition, there are important distinctions that differentiate juveniles from adult sex offenders (Association for the Treatment of Sexual Abusers, 1997b; Becker, 1998; Bonner, 1997). In fact, the appropriateness and ethics of the term "juvenile sex offender" have been called into question (Bonner, 1997). Language describing these young people as children or teenagers who have been sexually abusive (rather than as juvenile sex offenders) holds them accountable for their behavior yet does not suggest that they are and always will be disreputable sex offenders. Language that emphasizes the behavior rather than the person may help to avoid self-fulfilling prophecies that can contribute to offending behavior by promoting the belief that a person can never be more than his or her past. When the past includes sex offending, this can be a hopeless and esteem-deflating perspective.

Because most papers and studies in the literature have used the term "juvenile sex offenders," this term will be used, at times, in this review. Yet, it is important to consider the impact of language and begin to make appropriate changes.

Characteristics of Juveniles Who Have Committed Sex Offenses

Juveniles who have committed sex offenses are a heterogeneous mix (Bourke and Donohue, 1996; Knight and Prentky, 1993). They vary according to victim and offense characteristics. They also differ on a wide range of other variables, including types of offending behaviors, histories of child maltreatment, sexual knowledge and experiences, academic and cognitive functioning, and mental health issues (Knight and Prentky, 1993; Weinrott, 1996).

In spite of the apparent heterogeneity of juveniles who have sexually offended, findings from the few existing studies that compared juveniles who committed sex offenses with those who committed other types of offenses frequently have not revealed significant differences between samples (Becker and Hunter, 1997). This finding may suggest that a substantial number of juvenile sex offenders may not differ significantly from other juvenile offenders, although subgroups of juveniles who committed sex offenses do differ from juveniles who committed other offenses. Subgroups of juveniles who committed sex offenses are discussed in more detail in the section on Types and Classifications.

Offending Behaviors

Sexually Abusive Behaviors and Sex Offense Characteristics

As noted above, sexually abusive behaviors range from noncontact offenses to penetrative acts. In a study of Maine juveniles identified as having committed sex offenses (Righthand, Hennings, and Wigley, 1989), more than half of the abusive acts involved oral-genital contact or attempted or actual vaginal or anal penetration.

Offense characteristics include factors such as the age and sex of the victim, the relationship between the victim and the offender, and the degree of coercion and violence used. See table 1 for details of offense characteristics.

Nonsexual Criminal Behavior

Juvenile sex offenders frequently engage in nonsexual criminal and antisocial behavior (Fehrenbach et al., 1986; Ryan et al., 1996). Such behavior may, in fact, be quite typical of juvenile sex offenders, especially those who engage in forcible sexual assaults such as rape and attempted rape. In a national survey, Elliott (as cited in Weinrott, 1996) found that most of the 80 juveniles who disclosed sexually assaultive behavior had previously committed a nonsexual aggravated assault, whereas relatively few (7 percent) had perpetrated exclusively sex offenses. Nonsexual (violent and nonviolent) criminal behavior is correlated with repeated sexual violence by adult sex offenders (Chaffin, 1994; Hanson and Buissière, 1996) and may also be an important risk factor for repeated sex offending by juveniles.

Child Maltreatment Histories

The childhood experience of sexual abuse has been associated with juvenile sex offending (Fehrenbach et al., 1986; Kahn and Chambers, 1991; Kobayashi et al., 1995). Rates of juvenile sex offenders who have experienced sexual abuse as children reportedly range from 40 to 80 percent (Becker and Hunter, 1997). Yet, such abusive experiences of juvenile sex offenders have not consistently been found to differ significantly from those of other juvenile offenders (Lewis, Shanok, and Pincus, as cited in Knight and Prentky, 1993; Spaccarelli et al., 1997). Furthermore, Smith and Monastersky (1986)

Table 1: Sex Offense Characteristics

Domain	Characteristic
Victim Characteristics	◆ Female children are targeted most frequently.[a,b,c,d,e,f,g,h] ◆ Male victims represent up to 25 percent of some samples.[e,h,i]
Relationship Characteristics	◆ Victims are more often substantially younger than the offender, rather than peer age.[a,b,c,d,e,f,g,h,i] ◆ Victims are usually relatives or acquaintances; rarely are they strangers.[a,e,f,g,h,i] ◆ Babysitting frequently provides the opportunity to offend.[b,h]
Use of Aggression	◆ Although juvenile sex offenders usually are less physically violent than adult offenders, they may secure the victim's compliance via intimidation, threats of violence, physical force, or extreme violence.[a,j] ◆ Approximately 40 percent of the juveniles from a sample of 91 displayed expressive aggression in their sex offense(s).[d] ◆ Juveniles who victimized peers or adults tended to use more force than those who victimized younger children.[k]
Triggers	◆ Some of the "triggers" that have been described as related to sex offending include anger, boredom, and family problems.[g]

Notes: [a] Davis and Leitenberg, 1987; [b] Fehrenbach et al., 1986; [c] Hunter and Figueredo, 1999; [d] Miner, Siekert, and Ackland, 1997; [e] Rasmussen, 1999; [f] Righthand, Hennings, and Wigley, 1989; [g] Ryan et al., 1996; [h] Smith and Monastersky, 1986; [i] Wieckowski et al., 1998; [j] Knight and Prentky, 1993; [k] Becker, 1998.

found that among the juvenile sex offenders in their sample, there was a relationship between childhood experience of sexual abuse and higher rates of nonsexual reoffending but lower rates of sexual reoffending.

Not surprisingly, childhood experiences of being physically abused, being neglected, and witnessing family violence have been independently associated with sexual violence in juvenile offenders (Kobayashi et al., 1995; Ryan et al., 1996). Proportions of juvenile sex offenders who have experienced physical abuse as children reportedly range from 25 to 50 percent (Becker and Hunter, 1997). A study comparing juvenile sex offenders with juveniles who have committed nonsexual offenses suggests that sex offenders may have higher rates of childhood physical abuse (Ford and Linsey, as cited in Becker and Hunter, 1997). When juvenile sex offenders were compared only with juveniles who have committed nonsexual violent offenses, however, this result was not replicated (Knight and Prentky, 1993). This latter finding suggests that a history of physical abuse is correlated with some type of violent behavior but not necessarily with sexually violent behavior.

The role of child maltreatment in the etiology of sex offending appears quite complex (Prentky et al., 2000). One recent study (Hunter and Figueredo, as cited in Becker and Hunter, 1997) used several comparison and control groups to investigate factors associated with sex offending, such as a history of

sexual victimization and family support. The study found four variables predictive of sex offending: younger age at the time of victimization, higher rates of abusive incidents, longer period between abuse and disclosure, and lower level of perceived family support following the disclosure of the abuse.

Cooper, Murphy, and Haynes (as cited in Becker, 1998) compared juvenile sex offenders who had been sexually or physically abused with those who had not. They found that the abused juveniles began their sex offending 1.6 years earlier than the nonabused group, had twice the number of victims, were more likely to have both female and male victims, and were less likely to limit their offending to family members.

Other research on various offender groups suggests that offenders with histories of maltreatment begin offending at earlier ages than other offenders who were not maltreated. For example, Knight and Prentky (1993) found that rapists who began offending as juveniles had higher rates of emotional neglect as children than other rapists who began their assaults in adulthood. Child molesters who began offending as juveniles also had higher rates of physical abuse as children than did child molesters who began offending in adulthood. Although these samples did not differ significantly regarding the experience of intrafamilial sex abuse, child molesters who began offending as juveniles had higher rates of sexual victimization experiences throughout their childhood than did rapists who began their offending as adults. Rapists who began offending while still juveniles, as contrasted with those who began offending in adulthood, tended to come from families where sexually deviant or abusive behavior was directed at other family members. Data pertaining to an additional group of sex offenders, who had no official record of juvenile sex offenses but who admitted to such behavior in a confidential, computer-generated interview, were similar. In this group, offenders who began perpetrating as juveniles, contrasted with those who began as adults, had overall higher rates of childhood sexual victimization, their sexually abusive experiences began at younger ages, and the sexual assaults they experienced as children tended to be more severe (i.e., on a scale ranging from fondling to intercourse).

Social and Interpersonal Skills and Relationships

Family Factors

In addition to child maltreatment, factors such as family instability, disorganization, and violence have been found to be prevalent among juveniles who engage in sexually abusive behavior (Bagley and Shewchuk-Dann, 1991; Miner, Siekert, and Ackland, 1997; Morenz and Becker, 1995). Studies vary as to the percentages of these juveniles who are from intact families. Some studies (Kahn and Chambers, 1991; Fehrenbach et al., 1986) have found that less than one-third of the juvenile sex offenders in their samples resided with both birth parents.

Graves et al. (as cited in Becker, 1998) used statistical procedures (meta-analysis) to analyze the findings of multiple studies that were conducted over 20 years and described characteristics of juvenile sex offenders. The analysis resulted in identification of three groups of juveniles: sexually assaultive juveniles, whose victims were the offenders' peers or older; pedophilic juveniles, whose victims were at least 3 years younger than the offenders; and a mixed group, described as including juveniles who perpetrated more than one class of sex offense, including hands-off and hands-on offenses (Weinrott, 1996). The Graves et al. results (as cited in Becker, 1998) also indicated that juveniles who committed sexual assaults against victims who were their peers or older were more likely to come from single-parent homes (78 percent) than those who committed "pedophilic" offenses (44 percent) or mixed offenses (37 percent). Those who committed pedophilic offenses, however, frequently lived with foster or blended families (53 percent).

Miner, Siekert, and Ackland's (1997) study of incarcerated offenders revealed that only 16 percent of the juveniles in their sample came from intact families. The low rate of intact families, however, may reflect the nature of the sample (i.e., incarcerated juveniles).

In contrast to these studies, Cellini (1995) reported that approximately 70 percent of juvenile sex offenders lived in two-parent homes at the time their

abusive behavior was discovered. It was not clear, however, whether the two parents in these homes were both birth parents.

Together, these various studies suggest that many juvenile sex offenders have experienced physical and/or emotional separations from one or both of their parents. The cause of this separation may be family instability, parental separation or divorce, or residential placement of the juvenile.

Research on family factors affecting juvenile sex offenders has also examined family communication styles and types of family involvement with the juvenile. Studies have found that supportive communication and comments that facilitate dialog are limited in the families of juvenile sex offenders and violent offenders, whereas negative communication, such as aggressive statements and interruptions, are frequent (Blaske, Borduin, Henggeler, and Mann, as cited in Morenz and Becker, 1995). Not surprisingly, adequate support and supervision may be lacking in the families of these juveniles (Borduin, Henggeler, Blaske, and Stein, as cited in Hunter and Figueredo, 1999).

In a comparison study of juvenile sex offenders and other juvenile offenders in two residential treatment centers, sexually assaultive juveniles were described as typically coming from intact, "hothouse" families that frequently evidenced severe pathology, including child maltreatment (Bagley and Shewchuk-Dann, 1991). Although the sexually aggressive juveniles experienced less family instability (as defined by multiple male adult caregivers and/or desertions by their father figure), their parents evidenced higher levels of marital stress. Furthermore, the mothers and fathers of these juveniles had more mental health problems that required intervention, and the fathers evidenced slightly greater rates of alcohol abuse. Parents of juveniles in the sexually aggressive group also were more likely to be overly ambitious for their children and excessively critical of poor school grades.

Similarly, Miner, Siekert, and Ackland (1997) described the juvenile sex offenders in their sample as coming from "chaotic" family environments. Nearly 60 percent of the biological fathers had substance abuse histories, and 28 percent had criminal histories. Biological mothers, when compared to fathers, were less likely to have substance abuse histories (28 percent) or criminal histories (17 percent). The mothers, however, were more likely than the fathers to have a history of psychiatric treatment (23 percent versus 13 percent, respectively). Furthermore, nearly one-fifth of the subjects' siblings had criminal histories, and 29 percent of biological siblings and 20 percent of stepsiblings had psychiatric histories.

Smith and Israel (1987) found that some parents of juveniles who sexually abused their siblings were physically and/or emotionally inaccessible and distant. They also reported that some parents evidenced sexual pathology and exposed the juveniles to their sexual behaviors. Similarly, Miner and Crimmins (1995) found that sex-offending juveniles appeared to be more disengaged from their families than were other juveniles and, consequently, may have been cut off from possible sources of emotional support and less able to form positive attachments. This latter possibility gains some support from the finding of Kobayashi et al. (1995) that more positive relationships between juveniles and their mothers may be related to decreased levels of sexual aggression in juveniles. Weinrott (1996) reported there is strong evidence that family instability and problems in parent-child attachment in childhood are associated with more intrusive forms of juvenile sex offending.

Kimball and Guarino-Ghezzi (1996) found that the juveniles in their sample identified as child molesters reported significantly more ongoing conflict with a parental figure than was reported by juveniles identified as rapists. Rapists were significantly more likely than molesters to perceive their parents as not supportive of treatment. Stevenson and Wimberley (1990) opined, "The importance of family influences in the life of the adolescent sex offender cannot be underestimated as it is often the barometer of what can or cannot happen in treatment" (p. 59).

Social Skills and Relationships

Research repeatedly documents that juveniles with sexual behavior problems have significant deficits in social competence (Becker, 1990; Knight and Prentky, 1993). Inadequate social skills, poor peer relationships, and social isolation are some of the

difficulties identified in these juveniles (Fehrenbach et al., 1986; Katz, 1990; Miner and Crimmins, 1995). For example, Katz (1990) compared three groups—adolescent "child molesters," juvenile delinquents who had not committed sex offenses, and a comparison group recruited from a local high school[2] —on various measures of social competence. The juveniles who had committed child molestation offenses were more socially maladjusted than either of the other groups and evidenced more social anxiety and fear of heterosexual interactions. Miner and Crimmins (1995) found that juveniles who have sexually offended had fewer peer attachments and felt less positive attachment to their schools, compared with other delinquent juveniles and nondelinquent juveniles. In fact, they stated that this and other research—

> point to the primacy of isolation and poor social adjustment as distinguishing characteristics of adolescent sex offenders, indicating that interventions that maximize the ability to build interpersonal attachments potentially affect the propensity to engage in sexually abusive and aggressive behaviors. (pp. 9–11)

Sexual Knowledge and Experiences

Sexual Histories and Beliefs

Research suggests that adolescent sex offenders generally have had previous consenting sexual experiences (Becker, Kaplan, Cunningham-Rathner, and Kavoussi, as cited in Knight and Prentky, 1993; Groth and Longo, as cited in Knight and Prentky, 1993; Ryan et al., 1996). Research also suggests that sometimes their experiences have exceeded the experiences of control juveniles who have not committed sex offenses (McCord, McCord, and Venden, as cited in Knight and Prentky, 1993). Prior experiences with sexual dysfunction, most commonly impotence or premature ejaculation, have also been reported in juvenile sex offenders (Longo, as cited in Knight and Prentky, 1993). A study of 1,600 juvenile sex offenders described by 90 independent contributors from 30 States (Ryan et al., 1996) found that only about one-third of the juveniles perceived sex as a way to demonstrate love or caring for another person; others perceived sex as a way to feel power and control (23.5 percent), to dissipate anger (9.4 percent), or to hurt, degrade, or punish (8.4 percent).

Deviant Sexual Arousal

Studies of male college students and adult sex offenders have shown that deviant sexual arousal is strongly associated with sexually coercive behavior (Barbaree and Marshall, as cited in Hunter and Becker, 1994; Earls and Quinsey, as cited in Hunter and Becker, 1994; Prentky and Knight, as cited in Knight and Prentky, 1993). Controlled studies of deviant sexual arousal in juvenile sex offenders are lacking, although some related research has been reported.

In their sample of 197 juvenile sex offenders, Schram, Milloy, and Rowe (1991) found that sexual recidivists, defined as juveniles arrested for a new offense, were significantly more likely than other offenders to have deviant patterns of sexual arousal. Similarly, Kahn and Chambers (1991) found a trend associating deviant arousal and sexual reoffending, but it was not statistically significant. Both studies, however, relied on clinical judgments to determine the existence of deviant arousal, rather than more objective means such as phallometric assessment.

Knight and Prentky (1993) found that adult sex offenders who began offending as juveniles did not differ from those who began as adults in terms of preoccupation with sexual fantasies, problems with sexuality, or sexually deviant conduct. Knight and Prentky concluded this finding suggests that the importance of sexualization as an issue for juvenile sex offenders, as for adult sex offenders, may vary depending on the type of offender.

In their review of the role of deviant sexual arousal in juvenile sex offending, Hunter and Becker (1994) noted the limited research in this area and encouraged further investigations. They stressed that although deviant arousal may be more of a factor for sex offenders who target children (particularly those

[2] Some of the high school students in the comparison group may have had contact with the juvenile or criminal justice systems, but this number was assumed to be small.

who target boys), research suggests that juveniles who engage in sexually abusive behavior are a heterogeneous group. They also emphasized that the sexual interest and arousal patterns of these juveniles are more changeable than those of adult sex offenders and cautioned against applying to juveniles what is known about deviant arousal in adults.

Pornography

Investigations into the role of pornography in juvenile sex offending are limited in number. Becker and Stein (as cited in Hunter and Becker, 1994) found that only 11 percent of the juvenile sex offenders in their study reported that they did not use sexually explicit material. Approximately 74 percent reported that pornography increased their sexual arousal, 3 percent indicated it decreased their arousal, and 23 percent said it had no effect. There were no statistically significant differences between the subjects in terms of use of pornography and number of victims or in terms of types of pornography used and number of victims.

In a sample of 30 juveniles who had committed sex offenses, exposure to pornographic material at a young age was common (Wieckowski et al., 1998). The researchers reported that 29 of the 30 juveniles had been exposed to X-rated magazines or videos; the average age at exposure was about 7.5 years. Similarly, Ford and Linney (as cited in Becker and Hunter, 1997) found that 42 percent of juvenile sex offenders, compared with 29 percent of juvenile violent offenders (whose offenses were nonsexual) and status offenders, had been exposed to hardcore, sexually explicit magazines. The juvenile sex offenders also had been exposed at younger ages, ranging from 5 to 8. High rates of exposure to pornography also have been found for girls who have committed sex offenses (Mathews, Hunter, and Vuz, 1997).

Academic and Cognitive Functioning

Academic Performance

Studies typically report that, as a group, juveniles who sexually offended experienced academic difficulties (Fehrenbach et al., 1986; Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997; Pierce and Pierce, as cited in Bourke and Donohue, 1996). For example, Kahn and Chambers found that more than half of the juveniles in their study had evidenced at least one of three kinds of difficulty at school: disruptive behavior (53 percent), truancy (nearly 30 percent), or a learning disability (39 percent). Only 57 percent of the sample used by Fehrenbach et al. had achieved grade-appropriate placement or better. Pierce and Pierce found that 49 percent of the juvenile sex offenders in their sample had academic problems, 38 percent had been placed in special classes, and 14 percent were diagnosed as mentally retarded.

As part of an investigation of learning difficulties as a potential factor in sex offender treatment, Langevin, Marentette, and Rosati (1996) examined the case files of 162 male adult sex offenders who had participated in a treatment program and who had relevant data available. Fifty percent of the sample had repeated a grade. Although most of the subjects (43 percent) had repeated just one grade, 14 percent had repeated two grades and 3.5 percent had failed three or more grades. Seven others had been placed in special education classes as children. In all, 53 percent of the subjects apparently experienced learning difficulties during childhood.

Some juveniles who have sexually offended, however, do well in school. For example, O'Brien (as cited in Ferrara and McDonald, 1996) found that 32 percent of the offenders in his sample were described as above average in their academic performance.

Intellectual and Cognitive Impairments

Research that focuses on the intellectual and cognitive functioning of juveniles who have committed sex offenses is limited. Existing studies suggest that intellectual and cognitive impairments are factors that should be addressed (Awad, Saunders, and Levene, as cited in Knight and Prentky, 1993; McCurry et al., 1998). For example, in a comparative study of juvenile sex offenders and delinquents who had not committed sex offenses, the sex offenders had slightly lower IQ scores and more variability within subtests of standardized tests (Atcheson and Williams, as cited in Ferrara and McDonald, 1996).

In addition, more than one-quarter (25.2 percent) of the juvenile sex offenders had IQ scores below 80, whereas only 11.1 percent of the other delinquents scored in this range. Additionally, Saunders et al. (as cited in Ferrara and McDonald, 1996) found that violent juvenile sex offenders tended to have lower IQ scores than nonviolent sex offenders. Ferrara and McDonald argued that such differences may be attributed to higher rates of neurological impairments among violent offenders.

McCurry et al. (1998) noted that verbal deficits among juveniles who had conduct disorders and who scored within the average range on standardized tests were associated with higher rates of aggression and antisocial behavior. To investigate the role of verbal deficits in adolescents and children with inappropriate sexual behaviors, McCurry et al. studied 200 juveniles with serious psychiatric disorders, 99 of whom also evidenced inappropriate sexual behaviors such as hypersexuality (37 of the juveniles), exposing (24), and victimizing (38). Analyses revealed that, in general, subjects with lower IQ scores evidenced significantly more inappropriate sexual behaviors than did those with higher scores. This finding was especially true for subjects who molested or raped. Furthermore, subjects who evidenced the most serious inappropriate sexual behaviors had verbal IQ scores that were significantly lower than their performance IQ scores. The authors noted that deficits in verbal cognitive functioning, reflected by impulsivity and poor judgment, may contribute to the increased rates of serious inappropriate sexual behaviors among these juveniles. The authors stressed that treatment providers should consider the effects of verbal deficits when designing and applying interventions.

Lewis, Shanok, and Pincus (as cited in Ferrara and McDonald, 1996) investigated possible neurological deficits in a group of juvenile sex offenders and a comparison group of juveniles who had committed nonsexual but violently assaultive offenses. Psychological tests were administered,[3] and sleep electroencephalographs (EEG's) were performed when possible. The groups did not differ on full-scale, verbal, or performance IQ scores. Sex offenders evidenced greater difficulties on the reading test than the comparison group (5.59 versus 3.95 years below grade level, respectively). The results of the EEG's revealed the most direct evidence of neurological impairments among the juveniles from both groups: 23.5 percent of the sex offenders and 3.3 percent of the comparison group evidenced grossly abnormal EEG's or grand mal seizures. The finding of neurological impairments in both groups of juvenile offenders is consistent with other research regarding juvenile delinquents in general and violent juvenile offenders specifically (Ferrara and McDonald, 1996).

Academic functioning is not determined solely by intellectual or neurological functioning (parental level of education and support, truancy, and other variables are important); nevertheless, learning disorders are related to below-average academic achievement (Ferrara and McDonald, 1996). Furthermore, although the role of learning disabilities has not been well investigated, one study (O'Brien, as cited in Ferrara and McDonald, 1996) found that of a sample of 170 male adolescents who sexually offended, as many as 37 percent experienced learning disabilities.

The incidence of attention deficit disorders in juveniles with sexual behavior problems has not been satisfactorily examined. Kavoussi, Kaplan, and Becker (1988), however, found that of the 58 juveniles who had been evaluated or treated in an outpatient juvenile sex offender program, approximately 7 percent met the full diagnostic criteria for attention deficit disorder as specified in the *Diagnostic and Statistical Manual of Mental Health Disorders, 3rd Edition* (DSM–III). Nearly 35 percent of the juveniles evidenced some symptoms of an attention deficit disorder. Miner, Siekert, and Ackland (1997) found that more than 60 percent of the incarcerated juveniles in their study exhibited hyperactive and restless behaviors, and approximately 75 percent were identified as having attention problems, a learning disability, or both.

Although studies investigating specific areas of cognitive deficits in juvenile sex offenders are lacking, Ferrara and McDonald (1996) noted that research on juvenile delinquents has demonstrated two areas of impairment: difficulties with executive functions,

[3] Tests included the Wechsler Intellectual Scale for Children, Bender Gestalt, Woodcock Reading Mastery Tests, and Key Math Diagnostic Arithmetic Test.

such as planning, abstraction, inhibition of inappropriate impulses, and cognitive flexibility; and difficulties with receptive and expressive language. Studies as noted above suggest that at least some juveniles who sexually offend do not differ significantly from juveniles who commit other types of offenses and that some juvenile sex offenders experience cognitive deficits similar to those identified in other groups of juvenile offenders. Based on their review of the literature, Ferrara and McDonald concluded that between one-quarter and one-third of juvenile sex offenders may have some form of neurological impairment. They noted, "Furthermore, it is likely that the neurologically impaired juvenile sex offender who goes undetected will not attain the [optimal] benefit from treatment due to problems in concentration, comprehension, and memory" (p. 13).

In their study of the impact of learning difficulties in adult sex offender treatment, Langevin, Marentette, and Rosati (1996) observed that cognitive and neuropsychological testing revealed that the average level of intellectual functioning of the sample was in the average range. A closer examination, based on normative data, revealed that more than expected fell within the borderline range of intellectual functioning (i.e., IQ of 70–79), fewer than expected were within the "bright normal" range (IQ of 110–119), and more than expected fell within the very superior range (i.e., IQ of 130–140). Neuropsychological testing with the Halstead-Reitan Battery indicated that 33 percent of the sample scored within the impaired range.

Cognitive Distortions and Attributions

Knight and Prentky (1993) pointed out that some factors observed in abused children may have relevance for juvenile sex offenders who have been maltreated. For example, they cited studies indicating that abused children evidence less empathy than nonabused children, have trouble recognizing appropriate emotions in others, and have difficulty taking another person's perspective. This observation is consistent with research indicating that cognitive distortions, such as blaming the victim, were associated with increased rates of sexual reoffending among juveniles who committed sex offenses (Kahn and Chambers, 1991; Schram, Milloy, and Rowe, 1991).

Mental Health Issues

Symptoms and Disorders

Conduct disorder diagnoses and antisocial behavior frequently have been observed in populations of juveniles who have sexually offended (Kavoussi, Kaplan, and Becker, 1988; Miner, Siekert, and Ackland, 1997). For example, Kavoussi, Kaplan, and Becker found that the most common DSM–III diagnosis in their sample of male juvenile sex offenders was a conduct disorder (48 percent). Most of the juveniles were classified with the socialized, nonaggressive type. A much higher rate of conduct disorders was found among juveniles who had raped or attempted to rape adult women (75 percent).

In addition to conduct disorder diagnoses and antisocial traits, studies have described other behavioral and personality characteristics in juveniles who have sexually offended. For example, impulse control problems and lifestyle impulsivity have been associated with juvenile sex offending (Prentky and Knight, as cited in Prentky et al., 2000; Smith, Monastersky, and Deisher, as cited in Prentky et al., 2000). Carpenter, Peed, and Eastman (1995) found that adolescents who sexually offended against younger children evidenced higher scores on the Schizoid, Avoidant, and Dependent scales of the Millon Clinical Multiaxial Inventory (MCMI) than those who offended against age peers. These differences were statistically significant. Carpenter and colleagues also found that the degree of narcissism in the group of adolescents who offended against peers was within the clinically significant range, whereas the degree of narcissism in the group who offended against younger children was not clinically significant. The difference between the scores of the two groups on the narcissism scale was not, however, statistically significant. In another study, Schram, Milloy, and Rowe (1991) described slightly more than half of the juveniles in their sample of juvenile sex offenders as shy or immature.

Studies have indicated that juveniles who have sexually offended have higher rates of depressive symptoms than are found in the general juvenile population (Becker, Kaplan, and Tenke, as cited in Becker and Hunter, 1997; Kaplan, Hong, and Weinhold, as cited in Becker and Hunter, 1997). Sexually aggressive juveniles who had histories of childhood physical abuse or sexual abuse had higher rates of depressive symptoms, with as many as 29.2 percent of these offenders appearing severely depressed (Becker, as cited in Becker and Hunter, 1997). Becker and Hunter stressed that this finding illustrates the importance of evaluating whether juvenile sex offenders are experiencing symptoms of depression, especially if they have been victimized themselves.

Few studies of adolescents and children who evidence sexual behavior problems report major psychopathology in the subjects or their families (Becker, as cited in Ferrara and McDonald, 1996; Johnson, as cited in Ferrara and McDonald, 1996). Sexually aggressive juveniles placed in residential programs, however, evidence higher levels of "emotional disturbance," compared with other juveniles in these programs (Lewis et al., as cited in Ferrara and McDonald, 1996). Bagley and Schewchuk-Dann (1991) studied male juveniles in two residential treatment centers. They found that residents with sexual behavior problems, as compared with an age-matched control group of residents with no record of sexual problems, demonstrated higher levels of hyperactivity or restlessness; more depression and anxiety; more histories of fire setting, encopresis (defecation in inappropriate places), and running away; more early-onset neurological conditions or illnesses; more learning disorders; and health problems beginning at an earlier age. In contrast, juveniles from the control group were more aggressive toward peers and siblings and were more destructive of possessions and property.

Substance Abuse

Studies vary widely on the importance of substance abuse as a factor in sex offending among juveniles. Lightfoot and Barbaree (1993) reported that rates at which juvenile sex offenders were found to be under the influence of drugs or alcohol at the time they committed their offenses ranged from 3.4 to 72 percent. Although substance abuse has been identified as a problem for many juveniles who have sexually offended (Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997), the role of substance abuse in sex offending remains unclear, and for some juveniles, substance abuse may not be related to sex offending. Becker and Stein (as cited in Hunter and Becker, 1994) found that although 62 percent of the juvenile sex offenders in their study admitted to alcohol use, only 11 percent reported that alcohol use increased their sexual arousal. Statistical analyses indicated that the juveniles who reported increased arousal had more victims than those who said alcohol had no effect on their arousal or who said they did not drink. Illicit drug use was less commonly reported than alcohol use among these juveniles: 39 percent reported illicit drug use. Of these, approximately 23 percent reported that it increased their sexual arousal. There were no statistically significant differences between subjects in terms of drug use and number of victims.

As Lightfoot and Barbaree (1993) pointed out, assessments should differentiate substance abuse problems from "normative" experimentation that is part of the developmental process. They noted that classification schemes have been developed (George and Skinner, as cited in Lightfoot and Barbaree, 1993) to differentiate between infrequent, experimental, recreational, and chronic users and between different types of life problems associated with substance abuse among juvenile offenders (Lightfoot, Lightfoot, and Hodgins, as cited in Lightfoot and Barbaree, 1993). These authors stressed the importance of adequate assessments of substance abuse as part of a comprehensive evaluation of sex offenders. They pointed out that offenders who have evidence of organic impairment, possibly as a result of their substance abuse, are likely to require treatment similar to that required by offenders who are below average in intellectual functioning. Such treatment approaches should be simple and concrete, provide opportunities to rehearse new skills, and include strategies to facilitate the development and use of new skills in a variety of settings. The authors also noted that even among adolescents who are infrequent substance abusers, issues such as poor impulse control, problem-solving difficulties, and poor social skills can be exacerbated by even small amounts of

substance and, consequently, may increase the risk of sex offending. Lightfoot and Barbaree (1993) further suggested that whereas less frequent users may benefit from substance abuse treatment efforts that are part of a comprehensive treatment program, more chronic users may require more intensive substance abuse treatment efforts, possibly prior to treatment related to sex offending.

It appears that evidence is insufficient to identify substance abuse as a causative factor in the development of sexually abusive behavior, although substance abuse has a disinhibiting potential and, if present, may require intervention. For example, Miner and Crimmins (1995) found that the substance abuse histories of juvenile sex offenders were very similar to those of other adolescents, including both nonoffenders and juveniles who committed violent but nonsexual offenses. Although the three groups did not differ in their alcohol abuse, the violent nonsexual offenders had the highest rates of drug abuse. Yet, as Lightfoot and Barbaree (1993) have suggested, assessments of juveniles who have committed sex offenses would do better to determine not simply whether substance abuse is present in a juvenile's life but whether it is a risk factor for offending. If it is found to be a risk factor, the next step is to evaluate what interventions are required to reduce this risk.

Types and Classifications

Types and Classifications of Male Adolescents Who Have Committed Sex Offenses

Although a variety of characteristics have been identified among juveniles who have sexually offended, few studies have attempted to classify these juveniles according to their similarities and differences. Weinrott (1996) noted that even though it is widely accepted that juveniles who have abused young children differ from those who have sexually assaulted peers, most studies of juvenile sex offenders combine these groups. Furthermore, in spite of alarming statistics pertaining to the prevalence of juvenile sex offending, sexual recidivism rates for juvenile sex offenders typically are very low (Weinrott, 1996). The apparently low recidivism rate suggests that there may be a significant subgroup of identified juvenile sex offenders who do not continue to commit sex offenses as adults (Knight and Prentky, 1993). Such a finding would be consistent with the literature on juvenile delinquents (Tolan and Gorman-Smith, 1998). Yet, studies investigating this probability are lacking. Research on juveniles who commit sex offenses that differentiates these juveniles according to their various behavior patterns, cognitive and emotional functioning, and other relevant factors is needed to determine and apply appropriate and effective treatment strategies.

Becker and Kaplan (as cited in Becker, 1998) proposed that an initial sex offense by a juvenile results from a combination of individual factors such as a lack of social skills, family factors such as familial relationships, and social-environmental factors such as social isolation. They suggested that three paths are possible after the initial offense: a dead end (no further crimes), a delinquency path, and a sex interest path involving continued sex offending and, frequently, the development of deviant sexual arousal patterns. Becker (1998) pointed out that this hypothesized model, like other classification models, has not been empirically validated.

In 1986, O'Brien and Bera (as cited in Weinrott, 1996) grouped juvenile sex offenders into the following seven categories:

- Naive experimenters.
- Undersocialized child exploiters.
- Sexual aggressives.
- Sexual compulsives.
- Disturbed impulsives.
- Group influenced.
- Pseudosocialized.

Although this classification scheme has been described as having much "face validity" (Weinrott, 1996) and has been recommended to facilitate interventions and treatment (e.g., Avalon Associates, 1986), systematic investigations of its reliability and validity are lacking. Some indirect support for the O'Brien and Bera (as cited in Weinrott, 1996) classification scheme comes through the work of Knight and Prentky (1993). These researchers reported that four of the O'Brien and Bera types overlap with factors supported by the empirical literature and by their own research with adult offenders who committed sex offenses as juveniles.

Knight and Prentky (1993) compared adult sex offenders who had official records of juvenile sex offending with those who did not. They also compared

a third group of "hidden juvenile sex offenders"—individuals who reported they had committed sex offenses as juveniles but who did not have official records of such offenses. Their findings indicated that certain factors, such as low social competence and high rates of antisocial behavior and impulsivity, differentiated sex offenders who began offending as juveniles from those who did not. These factors also are significant in differentiating types of adult sex offenders. For example, of the nine rapist types, three—low social competence/opportunistic, low social competence/nonsadistic/sexual, and low social competence/vindictive—have low social competence as a defining characteristic. Combined, these findings suggest that the sex offender classification schemes validated by Knight and Prentky (1993) for adults may also be useful for differentiating juvenile sex offenders. The authors noted that social competence also is an important factor in the child molester typology, along with factors such as degree of sexual preoccupation and amount of contact with children.

Graves (as cited in Weinrott, 1996) conducted a meta-analysis of 140 samples involving 16,000 juvenile sex offenders. Results suggested three typologies: pedophilic, sexual assault, and undifferentiated. Pedophilic juveniles tended to lack social confidence and to be socially isolated, consistently molested much younger children (at least 3 years younger than themselves), and typically molested girls. The sexual assault group typically assaulted peers or older females. The undifferentiated group committed a variety of offenses, and the ages of their victims varied widely. This latter group engaged in hands-off offenses (e.g., exhibitionism) in addition to hands-on assaults. Compared with the other two groups, they began their abusive behavior when they were younger, had the most severe social and psychological problems, were more antisocial, and had more dysfunctional families.

Prentky et al. (2000) employed a rationally derived classification system to describe their sample of male juvenile sex offenders. They used the following six categories: child molesters (69 percent of the sample), rapists (12.5 percent), sexually reactive children (6.25 percent), fondlers (3 percent), paraphilic offenders (3 percent), and unclassifiable (6.25 percent). In the child molester category, all victims were under age 12 and offenders were at least 5 years older than victims. In the rapist category, all victims were age 12 or older and the age difference between offenders and their youngest victims was less than 5 years. Sexually reactive children were under age 11, as were their victims. In the fondler category (as in the rapist category), all victims were age 12 or older and the age difference between offenders and their youngest victims was less than 5 years; sexual acts in this category were limited to fondling, caressing, or frottage (i.e., touching or rubbing against a nonconsenting person for sexual arousal). Paraphilic offenders had no physical contact with their victims; acts included, for example, exhibitionism and obscene phone calls. Prentky et al. (2000) reported that these categories also were used by Becker and Kaplan, who found similar proportions of offenders in each category (with the exception of a somewhat higher proportion of rapists).

Weinrott (1998a) suggested four general types of juveniles who have sexually abused others. Three of these types are those who are juvenile delinquents in general, those who have deviant arousal, and those who are psychopathic offenders. The other type includes juveniles who fit none of these categories and may only require limited interventions, such as those that establish appropriate rules for future sexual behavior.

Malamuth's research with college students (as cited in Miner and Crimmins, 1995) suggested that sexual aggression resulted from the interaction of two pathways: hostile masculinity and sexual promiscuity. Hostile masculinity involves beliefs that to be male involves taking risks; being powerful, tough, dominant, competitive, and aggressive; and defending one's honor. The sexual promiscuity pathway reflects age at first intercourse and number of sexual partners since the age of 14. High scores on both pathways were associated with high rates of sexual aggression against women.

Sibling Incest

Few reports have specifically addressed issues pertaining to sibling incest. Araji (1997) noted that although sibling incest appears to be quite prevalent, often it is underreported and ignored. Various

factors probably contribute to this apparent tendency to minimize the incidence of sibling abuse. For example, in contrast to extrafamilial sexual abuse, parents may be especially reluctant to report to authorities that one of their children has sexually abused another child in their home.

O'Brien (1991) emphasized the importance of "Taking Sibling Incest Seriously" with the title of his paper. He compared 170 juveniles who sexually offended against siblings (including stepsiblings, half siblings, and adoptive siblings) with extrafamilial offenders (those who offended against children other than their siblings), those who sexually victimized peers or adults, and those whose victims may have included a mix of sibling and extrafamilial children and/or peers and adults.[4] As a group, sibling offenders perpetrated the greatest number of abusive acts (an average of 18 incidents, compared with 4.2 for extrafamilial offenders, 7.4 for peer/adult offenders, and 8.5 for the mixed group). The duration of sex offending was greatest for sibling offenders. Nearly 45 percent of the sibling offenders had been committing offenses for more than a year, whereas only 23 percent of the extrafamilial offenders and 24 percent of the adult/peer offenders had been offending for this long. In addition, the sibling offenders were more likely than the others to vaginally or anally penetrate their victims (46 percent, compared with 28 percent of the extrafamilial offenders and 13 percent of the adult/peer offenders). Sibling offenders also were more likely to have multiple victims. O'Brien hypothesized that specific issues, such as victim availability, the nature of the sibling relationship, and other factors, may have contributed to such serious offending histories. In spite of such abusive behaviors, only about one-third of the sibling offenders had court-ordered treatment, compared with three-quarters of the other offenders.

Family factors such as an increased rate of physical abuse were noted among the sibling offenders (61 percent, compared with 45 percent of the extrafamilial offenders and 37 percent of the adult/peer offenders). Sibling offenders also were sexually abused more frequently by their fathers than were other offenders, although only a small number of the sibling offenders had been sexually abused by any family member (including fathers). Interestingly, 36 percent of the sibling offenders' mothers and 10 percent of their fathers had been victims of sexual abuse as children, compared with 9.1 percent of the extrafamilial offenders' mothers and 5.5 percent of their fathers. Assessments also suggested that the rate of family dysfunction was higher for sibling offenders than for the other groups.

An early study of inner-city minority juveniles from low socioeconomic backgrounds (Becker et al., 1986) questioned the existing assumption that sibling offenders are significantly different from other juvenile sex offenders. Becker et al. noted that 9 of the 22 adolescents in their small sample also had evidenced nonsibling paraphilic behaviors. In view of the O'Brien (1991) study that found significant group differences between sibling and nonsibling sex offenders, it may be that, as in any group of sex offenders, juveniles who perpetrate sibling abuse are a heterogeneous mix. In fact, Becker and her colleagues noted that the juveniles in their sample included adolescents who engaged in consensual sexual behavior with a peer-aged relative, those whose sexual activity with a peer-aged relative began as consensual but became coercive when the relative withdrew consent, those who had developed deviant sexual interests, and those who engaged in both nondeviant and deviant sexual behavior.

In their discussion of sibling abuse, Bonner and Chaffin (1998) asserted that most interventions designed to address sibling sexual behavior assume a victim-perpetrator model. They noted that such a model may be appropriate when the sexual behavior has been abusive but cautioned that it is progressively less appropriate (and may be damaging) when sibling cases involve inappropriate mutual sexual behavior or, especially, age-appropriate sex play.

[4] Information about the number of abusive acts was provided for all groups. Information about the duration of offending and other reported variables was provided for sibling, extrafamilial, and peer/adult offenders but not for the mixed group.

Girls Who Have Committed Sex Offenses

Incidence

Before 1986, references in the professional literature to female sex offenders were few and limited. Since then, some references have appeared, but research studies continue to be few, and studies of adolescent girls are relatively rare. Existing studies often are limited by small sample sizes and retrospective analysis of selected populations that may not be representative of the general population.

Lane and Lobanov-Rostovsky (1997) reviewed the literature on young sex offenders and found that adolescent female sex offenders represented between 2 and 3 percent of juveniles involved in two different treatment programs. These authors also cited the results of several statewide incidence studies conducted in the 1980's. The studies revealed that females represented 5 percent (19) of the juveniles arrested for sex offenses in Oregon in 1985, 8 percent (12) of the children identified as adolescent sex offenders by the Vermont Social Rehabilitation Services Department or Corrections Department in 1984, and 7 percent of the juveniles referred to juvenile court in Utah over a 5-year period. In a Maine study (Righthand, Hennings, and Wigley, 1989), females represented 11 percent (40) of the 348 juveniles identified as sex offenders by the Maine Departments of Human Services and Corrections during a 12-month period between 1988 and 1989.

In a more recent study by the Washington State Department of Social and Health Services, English and Ray (as cited in Araji, 1997) found that of 200 juveniles identified as sexually aggressive, 9.3 percent of those age 13 or older were female, compared with 19.1 percent of those age 12 and under. This relatively high rate of sex offending by young girls also was found by Johnson (as cited in Lane and Lobanov-Rostovsky, 1997). Girls who had been sexually abusive made up 21.6 percent of the children in her program for children ages 4 to 12 who had engaged in inappropriate sexual behavior. Gray et al. (1997) also found a relatively high rate of preadolescent girls who evidenced sexual behavior problems. In their sample, 35 percent of the children who evidenced such problems were girls.

Incidence reports on juvenile sex offenses may underestimate the extent of the problem for female offenders even more than for male offenders. Underestimates may occur because there is a general tendency to underreport sex crimes committed by females (Charles and McDonald, 1997). It has been hypothesized that this underreporting might result from a societal reluctance to acknowledge that girls are capable of committing criminal offenses, particularly sex offenses; even professionals may be reluctant to report female disclosure of sex offenses (Travin, Cullen, and Protter, 1990).

Characteristics of Female Offenders and Their Offenses

Ray and English (1995) compared girls and boys who were described as sexually aggressive and who were actively involved with their State's public social service agency. Findings indicated that the girls tended to be younger than the boys and were less likely to have perpetrated acts of rape. (Rape was defined as involving force or no consent and vaginal, oral, or anal penetration with a penis or object.) Approximately 94 percent of the girls in the sample had been victims of sexual abuse, compared with 85 percent of the boys. A greater percentage of girls than boys (94 percent versus 86 percent) had experienced multiple types of abuse, including sexual abuse, physical abuse, emotional abuse, and/or neglect.

All of the children in the Ray and English sample (1995) evidenced a wide range of behavior problems while under the State agency's supervision. Girls were significantly more likely than boys to steal and display temper tantrums. There also was evidence that girls were more likely to be truant. Girls appeared to have more adequate social skills and more empathy toward their victims, whereas boys tended to be more coercive and sophisticated in their sex offending. Use of sexual aggression appeared to be escalating more in boys than in girls. Another noteworthy difference was that although approximately one-third of all the juveniles studied were legally charged with an offense, only 2 girls (as contrasted

with 93 boys) were charged. The study also found that girls were significantly more likely than boys to receive assessment and treatment for their experiences of being abused.

Fehrenbach and Monastersky (as cited in Bumby and Bumby, 1997) found that, in their sample, most adolescent girls who sexually victimized children age 12 or younger frequently did so while engaged in a childcare situation. In their sample, 53.6 percent of the adolescent girls committed some form of penetration (oral, anal, or vaginal intercourse or other forms of penetration); 46.4 percent engaged in fondling.

Hunter et al. (as cited in Bumby and Bumby, 1997) conducted a descriptive study of 10 girls who had sexually offended and who were in a residential care program for juveniles with emotional and behavioral problems. The study, although limited by the small sample size and lack of a comparison group, is informative. The girls had high rates of previous mental health services (80 percent). Many had a history of suicide attempts or ideation (60 percent), running away (60 percent), substance abuse (40 percent), enuresis (bed wetting, 40 percent), and/or learning disabilities (40 percent).

All of the girls reported a history of sexual victimization experiences, including the following:

- All had been sexually abused by more than one offender; the number of offenders ranged from two to seven.
- Experience of victimization began at early ages, ranging from 1 to 8 years; the median age was 4.5 years.
- All of the girls reported being sexually abused by a male; 60 percent also reported being abused by a female.
- Ninety percent of the girls reported actual or attempted vaginal penetration, 60 percent reported actual or attempted anal penetration, 70 percent reported having oral sex performed on them, and all reported being fondled.
- Ninety percent reported that force was used in their sexual victimization experiences, yet 80 percent reported that they experienced some sexual arousal during at least one of their experiences as a victim.

In regard to their sex-offending behavior, these girls reported the following:

- They typically victimized younger children; victim ages ranged from 1 to 13 years, with a median age of 5.5 years.
- Their victims most frequently were strangers (39.4 percent); other victims were siblings (30.3 percent), other relatives (18.2 percent), and acquaintances (12.1 percent).
- They had fantasies about the deviant sexual behavior (in 89 percent of the cases).
- Their sexually offensive behavior included vaginal intercourse (70 percent), anal intercourse (10 percent), oral sex (70 percent), and fondling (100 percent).

Most of the girls in this sample also engaged in nonsexual delinquent behaviors such as stealing and physical aggression. Most had not been formally charged for these behaviors.

The findings of the above studies are fairly consistent with Bumby and Bumby's (1997) findings from their sample of 12 adolescent female offenders who were inpatients at a psychiatric facility for children and adolescents with emotional and behavioral disorders. Again, the girls in this sample tended to select young victims. Most often their victims were family members (75 percent). In contrast to the sample studied by Hunter et al. (as cited in Bumby and Bumby, 1997), none of these girls victimized strangers. Eleven of the twelve girls perpetrated their offenses when providing childcare.

A review of the characteristics of the girls in the Bumby and Bumby (1997) sample indicated that most (83 percent) experienced academic difficulties, although all but three fell within the average intellectual range; all but one had peer difficulties at school; and two-thirds had been suspended or expelled for physical aggression toward peers or teachers or for other causes. Behavior problems were common: 75 percent had abused alcohol, 58 percent had abused drugs, 58 percent had run away from

home, 58 percent had been truant from school, and 33 percent had been arrested for stealing. Psychiatric diagnoses included conduct disorders, oppositional-defiant disorder, major depression, posttraumatic stress disorder, adjustment disorder, and chemical dependency. Most (83 percent) had received previous mental health services, 33 percent had histories of self-mutilation, and 58 percent had attempted suicide. Anger control problems were described as common (67 percent), as were low self-concepts (100 percent). Peer relations were very strained; 75 percent of the girls were described as significantly socially isolated, which possibly was related to their high rate of aggressive behavior toward peers (67 percent). A significant number (58 percent) were described as sexually promiscuous, having had many sexual relationships with older males. All of these girls had been sexually victimized themselves. They tended to have been sexually abused by more than one person. Seventy-five percent had been physically abused, and 42 percent had experienced emotional or physical neglect. In general, their families were described as dysfunctional and chaotic.

To provide additional information about their adolescent sample, Bumby and Bumby (1997) compared 18 female sex offenders to a group of female nonoffenders, male sex offenders, and male nonoffenders of similar age. All juveniles were inpatients at a psychiatric facility for children and adolescents with emotional and behavioral disorders. Psychological test results suggested that the adolescent female sex offenders experienced a number of psychological symptoms and difficulties. They had higher scores than the female nonoffenders on the psychopathic deviate, paranoia, and psychasthenia scales of the Minnesota Multiphasic Personality Index-Adolescent (MMPI–A). They did not, however, differ significantly from the male sex offenders and male nonoffenders.

The female sex offenders evidenced significantly more symptoms of anxiety and depression (including suicidal thoughts and behaviors) than the female nonoffenders but did not differ from the male sex offenders in this regard. The female sex offenders had higher rates of academic failure (having been retained for one grade in school) and truancy than the male sex offenders but did not differ from the female or male nonoffenders on these measures. Although delinquent behaviors, socially inappropriate behaviors, and status offenses were frequent among female sex offenders, the frequency did not differ significantly from that found in the other groups, with the exception that female sex offenders had higher rates of drug abuse and sexual promiscuity than the male sex offenders. In addition, although high rates of childhood sexual victimization occurred across all groups, the female sex offenders experienced significantly more sexual abuse than the other groups.

Again, these findings are informative but are limited by the small sample size. The authors point out, however, that their findings are consistent with the limited available information. The authors suggest that factors such as depression, suicidal ideation, anxiety, poor self-concept, and childhood sexual victimization are targets for assessment, and possibly treatment, in girls who commit sex offenses.

In perhaps the largest study to date, Mathews, Hunter, and Vuz (1997) compared 67 girls who were referred to community-based treatment or residential treatment subsequent to histories of sex offending with 70 boys who also had such histories. Because the samples did not meet scientific standards of comparability, statistical tests of differences between groups could not be used. A review of the findings, however, suggested some meaningful similarities and differences between the girls and the boys. The girls' offending behaviors were similar to the boys' in terms of offense types and style of victim selection. For example, both girls and boys committed the following types of offenses: fondling (77.6 percent girls, 75.4 percent boys), oral sex (47.8 percent girls, 29.7 percent boys), and vaginal or anal intercourse (26.9 percent girls, 54.5 percent boys). Also like the boys, the girls tended to victimize young children of the opposite gender. In contrast to the boys, and consistent with other studies, the girls typically had more severe victimization experiences themselves.

These abusive experiences were characterized by a higher average number of perpetrators, younger age at the time of first victimization, and greater likelihood of having been a focus of their perpetrator's aggression. Girls also were three times more likely than boys to have been victimized by female perpetrators. Like boys, however, the girls' victimization by a perpetrator of the same gender seemed related to the girls' having sexual identity problems.

Other findings in Mathews, Hunter, and Vuz (1997) indicated that in addition to experiencing high rates of abuse and trauma, the girls in this study typically came from families evidencing high levels of dysfunction and an absence of parental support. Their family environments usually appeared detrimental for the development of healthy attachments and a positive sense of self. Although a small subgroup of the girls evidenced little psychopathology and limited offending behaviors, about one-third of the outpatient girls in the study evidenced mild to moderate levels of psychopathology, and about half of the entire sample appeared to have moderate to severe psychopathology. Problems included behaviors associated with conduct disorders, impulsivity, substance abuse, suicidal behaviors, and unprotected sex. A subgroup of the girls also evidenced deviant sexual arousal patterns, posttraumatic stress disorder, depression, and anxiety. In sum, the authors concluded:

> Overall, the data from this study seem consistent with the authors' impression that biological and socialization factors create a higher threshold for the externalization of experienced developmental trauma in females than males. In this regard, it may be that females are generally less likely than males to manifest the effects of maltreatment in the form of interpersonal aggression or violence and that females who develop such patterns of behavior are generally those who have experienced remarkably high levels of such developmental trauma in the absence of environmental support for recovery and the presence of healthy female role models. (p. 194)

Young Children Who Have Committed Sex Offenses

Incidence

In the 1980's, after the problem of adolescent sex offending gained attention, similar behaviors in preadolescent and younger children also were recognized. Knopp (as cited in Araji, 1997) observed that the 1980 Uniform Crime Reports identified 208 children under the age of 12 who were arrested for rape. Thirty-seven of these children were age 10 or younger. Knopp found somewhat higher rates for 1979: in that year, 249 children under the age of 12 were arrested for rape; 66 of these children were age 10 or younger. The Uniform Crime Reports stopped reporting age ranges in 1980 (Araji, 1997).

Recent surveys of children with sexual behavior problems (including nonajudicated children) reveal substantially higher rates of sexually abusive behavior by preadolescent children than the rates cited in the Uniform Crime Reports. For example, English and Ray (as cited in Araji, 1997) reported that the Washington Department of Social and Health Services had 641 active cases of children under age 12 who had raped, molested, or engaged in noncontact sexual acts such as exposing, masturbating in public, or peeping. Gray and Pithers' Vermont studies (as cited in Araji, 1997) identified 200 children under age 10 who had sexually abused others between 1984 and 1989; even more striking, they identified 100 children who had sexually abused others in a single year, 1991. In addition, in a sample of 616 juveniles who had been referred for evaluation or treatment after the age of 12 for committing a sex offense, 25.9 percent had been sexually abusive prior to their 12th birthday (Ryan et al., 1996). This apparent increase in the rate of preadolescent children who evidence sexually abusive behaviors probably reflects a greater awareness of the problem.

In an extensive review of the published and unpublished literature pertaining to children who have been sexually aggressive, Araji (1997) stressed that research in this area is in its infancy and noted that many findings are simply clinical observations. Araji's point has relevance for the findings presented in this Report: because this area of research is so

new, the findings presented must be considered preliminary and interpreted with caution.

Individual Characteristics

With this caution in mind, available studies (Araji, 1997) have reported that preadolescent children who have been sexually aggressive include children as young as 3 and 4, although the most common age of onset appears to be between 6 and 9. Contrary to findings regarding adolescent children who have committed sex offenses, girls were represented in much greater numbers among preadolescents who have sexually abused. Furthermore, these girls had often engaged in behaviors that were just as aggressive as the boys' actions. The number of reported victims for these preadolescent children ranged from one to nine; many had multiple victims. Victims tended to be quite vulnerable. They generally were young (averaging between ages 4 and 7); typically were siblings, friends, or acquaintances; and most often were female.

Studies generally have found high rates of sexual victimization histories among preadolescent children who have sexually abused: 50–75 percent of the boys and 100 percent of the girls in studies that provided this information by gender (Johnson, as cited in Araji, 1997; Friedrich and Luecke, as cited in Araji, 1997; Araji, Jache, Tyrrell, and Field, as cited in Araji, 1997; Araji, Jache, Pfeiffer, and Smith, as cited in Araji, 1997; Bonner, Walker, and Berliner, as cited in Araji, 1997; Pithers et al., 1998b). English and Ray (as cited in Araji, 1997) found that preadolescent children who have sexually abused have significantly higher rates of abuse and neglect victimization experiences than their adolescent counterparts. Furthermore, Friedrich and Luecke (as cited in Araji, 1997) also found severe sexual victimization experiences among sexually aggressive children when contrasted with two samples of children who were not sexually aggressive (one with a history of sexual victimization and one without). The children who were sexually aggressive experienced more severe types of sexual abuse that generally involved genital contact and penetration. Research by Friedrich and Luecke (as cited in Araji, 1997) and Pithers and Gray (as cited in Araji, 1997) also suggests that the children who engaged in sexually aggressive behaviors frequently experienced academic and learning difficulties and impaired peer relationships.

Family Characteristics

Studies described by Araji (1997) also suggest that the families of children who engaged in sexually aggressive behavior tended to be characterized as dysfunctional, evidencing high rates of parental separation, domestic violence, substance abuse, highly sexualized environments (e.g., exposing children to sexual activity, pornography, and both covert and overt sexual abuse), unsatisfactory role models, poor parent-child relationships, parental histories of childhood abuse, and so on. After reviewing the available research, Araji concluded, "The evidence . . . points to family interactions as a primary source of the problem" (p. 87).

The importance of family factors is supported by research conducted by Pithers et al. (1998a) concerning the caregivers of children with sexual behavior problems. These researchers used a structured interview and standardized measures to investigate the characteristics of these caregivers. Findings indicated that the caregivers and their families experienced much stress. Of the 72 children in the study (75 percent of whom resided with biological parents and 25 percent with foster parents), 38 percent resided in families whose income fell below the Federal poverty level (defined as a family of four or more with an annual income of less than $15,000). Comparisons between biological families and foster families revealed that 72 percent of the biological families and 28 percent of the foster families had incomes below the poverty level. Families also had a high rate of single parenting: approximately half of the parents (51.4 percent) were living with a partner.

The family environments of these children, particularly their biological families, were characterized as disorganized and as requiring much effort to meet the basic needs of the family. The families had a high rate of sexual abuse histories. Most families (72 percent) included at least one sexual abuse victim (other than the child being studied), and more than half of the extended families (62 percent) included at least one person (other than the child being studied) who had perpetrated sexual abuse. Sexual

abuse victims of the children studied typically were relatives (94 percent). Very few of these children assumed responsibility for their sexually abusive behaviors (10.3 percent).

More than half of the children studied had witnessed domestic violence in the families with whom they were currently residing. Most witnessed violence between their biological parents (70.2 percent). Some observed partner violence in their foster homes (20 percent). In general, foster families seemed to provide more functional environments, experienced less conflict, and were more cohesive.

The individual functioning of the female caregivers[5] was measured with the Brief Symptom Inventory (Derogatis, as cited in Pithers et al., 1998a; Derogatis and Spencer, as cited in Pithers et al., 1998a). The results suggested that, as a group, these women were significantly more psychologically distressed than most people in the general population. The biological parents evidenced significantly more distress than the foster parents. Parenting stress among female caregivers was measured by the Parenting Stress Inventory (Abidin, as cited in Pithers et al., 1998a). Both biological and foster parents appeared to experience significant parenting stress that warranted referrals for professional care. Again, the biological parents evidenced significantly more stress than the foster parents. Both groups cited their children as a major source of their parenting stress, and both groups evidenced impaired attachments to their children. In spite of these findings, parents typically denied having problems associated with parenting and appeared defensive about some personal difficulties.

Comparative Studies of Preadolescents and Adolescents Who Have Committed Sex Offenses

In one of the few existing comparative studies involving children who committed sex offenses, English and Ray (as cited in Araji, 1997) studied 271 juveniles who sexually offended by comparing the preadolescents (32.8 percent) with the adolescents (67.2 percent). Although the researchers found many similarities between the groups (e.g., previous aggressive behavior, psychiatric problems, and levels of intellectual functioning), the adolescents evidenced significantly higher rates of aggression and coercion and greater sophistication in committing their sex offenses. The older juveniles also were less empathic, were more likely to minimize the seriousness of their abusive behavior, and evidenced more escalating sexual violence. The adolescents also had higher rates of depressive symptoms and suicidal gestures. As Araji suggested, this latter difference may reflect developmental differences between the groups, as the older juveniles may have begun to internalize their difficulties in addition to expressing them outwardly.

English and Ray (as cited in Araji, 1997) also found that both groups had a moderate to moderately high number of risk factors that were considered by the authors to be associated with repeat offending. (The authors evaluated 32 risk factors in 3 categories: family and environment, juvenile characteristics, and victim characteristics.) The preadolescent children's families, however, evidenced significantly more family violence, anger management difficulties, blurred boundaries regarding the privacy of family members, family abuse histories, and parental problems coping with the child's alleged sexual misconduct. In addition, the younger group had significantly higher levels of social isolation and current life stresses.

Types and Classifications

Although, as noted below, some research studies have substantially advanced the body of knowledge about younger children who are sexually abusive and their difficulties, longitudinal studies following these children over time are lacking. Thus, it is not known whether childhood sexual behavior problems continue or, more accurately, which children persist in their sexual misconduct in adolescence or through adulthood.

Children who have sexual behavior problems are a heterogeneous group. Descriptions of these children typically differentiate normative sexual behavior exhibited by children from a continuum of progressively

[5] The authors (Pithers et al., 1998a) noted that psychometric test results were reported for female caregivers only (94.5 percent of the sample), to facilitate the comparison of their scores with published norms.

more excessive and abusive sexual behaviors (Araji, 1997; Johnson, 1991).

For example, Johnson (1991) described children referred for evaluation or consultation because of reported sexual acting-out behavior and identified four groups: normal sexual exploration, sexually reactive, extensive mutual sexual behaviors, and child perpetrators. Factors that distinguish these groups are as follows:

- Normal sexual exploration is an "information-gathering process" that involves children looking at and touching each others' bodies and trying out gender roles. The sex play is voluntary and typically involves same-age children. It usually is spontaneous and light hearted.
- Sexually reactive children have been sexually abused, have been exposed to pornography, and/or live in highly sexualized households. The behaviors of these children include exposing, touching the genitals of other children or adults, self-stimulating genitals or inserting objects, and so on. The emotions associated with these behaviors may reflect confusion and shame.
- The children in the extensive mutual sexual behavior group participate in extensive sexual behaviors on a continuous basis, including oral sex, vaginal intercourse, and anal intercourse. They do not appear to experience anxiety, guilt, shame, or confusion, and they evidence little desire to stop. The sexual activity is mutual; there is no offender or victim. Most of these children have previously been sexually abused. Sometimes their sexual behavior appears as a coping strategy in very chaotic, dysfunctional, and/or sexually abusive families. Some of these children have been placed in multiple foster homes and appear to cling to each other in this sexual way to assuage their feelings of fear and loneliness.
- The child perpetrator group includes children who engage in impulsive, compulsive, and aggressive sexual behavior. The sexual behaviors are not mutual and involve coercion, trickery, bribery, and force. The children in this group often associate feelings of anger and aggression (and sometimes rage) with sex. Other feelings associated with sex include fear, loneliness, or abandonment. These children typically have been exposed to high levels of sexual violence (including incest), promiscuity, pornography, and sexualized relationships.

Based on her literature review and her own research, Araji (1997) also conceptualized a subgroup of children who are comparable to children in Johnson's child perpetrators group. These "sexually aggressive children" are at the extreme end of a childhood sexual behavior continuum. Their sexual behaviors tend to be more aggressive and involve force, coercion, and secrecy. Their sexually abusive behaviors typically are repetitive and may increase in frequency over time. Araji also suggested that the sexually abusive behaviors of these children may indicate a need to reduce negative emotions (such as anger, fear, or loneliness) and may also express a felt need for power. Araji stated that these children require intense, specialized interventions and are likely to be the most resistant to treatment.

In what appears to be the first attempt to develop empirically derived and clinically relevant classifications of children with sexual behavior problems, Pithers et al. (1998b) studied a sample of 127 children ages 6 to 12 who had evidenced sexual behavior problems. The authors defined "problematic" as sexual behaviors that were "(a) repetitive; (b) unresponsive to adult intervention and supervision; (c) equivalent to adult criminal violations; (d) pervasive, occurring across time and situations; or (e) highly diverse, consisting of a wide array of developmentally unexpected sexual acts" (p. 386).

Pithers et al. (1998b) found that children who evidenced sexual behavior problems varied significantly on several factors, including historical, demographic, behavioral, and diagnostic factors. They also varied according to number of victims, degree of aggression used during the sexual abuse, sexual penetration, psychiatric diagnoses, and internalizing and externalizing behaviors. Five subtypes were identified: sexually aggressive, nonsymptomatic, highly traumatized, abuse reactive, and rule breaker. Factors that distinguish these subtypes are as follows:

- The sexually aggressive children tended to have the highest rates of conduct disorder diagnoses. They were more likely to penetrate their victims and less often were victims of sexual or physical abuse themselves.
- The nonsymptomatic children were, as the classification name implies, within the normal range on most test measures. They typically did not have psychiatric diagnoses, evidenced low levels of aggression in their sexual behaviors, and had the fewest victims. These children were some of the most likely children to have in their extended family persons who had perpetrated sexual abuse.
- Both the highly traumatized children and the abuse reactive children typically were among the youngest and had the highest average number of victims. These two groups of children also had been victimized by the greatest number of sexual and physical abuse perpetrators.
- The highly traumatized children had the highest incidence of psychiatric diagnoses and posttraumatic stress disorders. Their parents were more likely than other parents to report feeling less attached to their children.
- The abuse reactive children had the shortest time between their own personal victimization experiences and the onset of their abuse against others. They experienced a high level of maltreatment and had a high number of sexual abuse perpetrators. This group had a high incidence of psychiatric diagnoses and the highest incidence of oppositional defiant disorders. They occasionally used aggression during their offenses.
- The rule-breaking group included a higher number of girls and had a greater time lag between their own victimization experiences and the onset of their abuse against others. These children had higher levels of sexualized and aggressive behaviors and also were more likely to act out in nonsexual ways. They had the highest number of sexual abusers within their extended families.

Across all five subtypes, certain factors were found to be associated with the number of victims abused by these children. The children who themselves had been abused by more perpetrators and the children who had impaired attachments with their parents had greater numbers of victims.

Juveniles With Developmental Disabilities and Mental Retardation Who Have Committed Sex Offenses

In one of the few studies focusing on adolescent sex offenders with mental retardation, Gilby, Wolf, and Goldberg (1989) compared sexual behavior problems in a sample of intellectually normal (defined by the authors as borderline intellectual functioning or higher) and mentally retarded (including mild and moderate mental retardation) adolescents. The sample included both outpatient and inpatient adolescents at an assessment and treatment center for children and adolescents. The authors found that the frequency of sexual behavior problems of the groups studied did not differ significantly according to their levels of intellectual functioning. They noted that, for both the "intellectually normal" and "mentally retarded" groups, the closer the adolescent was observed (e.g., within a residential setting), the greater the number of sexual behavior problems recorded. This finding was especially true for the mentally retarded inpatient group. The authors suggested that reports of a greater-than-expected number of sexual problems among persons with mental retardation may be related to the increased levels of supervision these individuals receive.

Gilby, Wolf, and Goldberg (1989) found increased levels of inappropriate, nonassaultive sexual behavior (e.g., exhibitionism and public masturbation) among the adolescents with mental retardation. Although the rate of sexual assault did not vary between the intellectually normal and mentally retarded groups, there were fewer "consented to" sexual activities among the mentally retarded outpatient group. The authors suggested that this difference could reflect a lack of opportunity. The authors also noted that sexual activity was frequent in both groups of adolescents once they were placed in residential settings. The adolescents with mental retardation, however, reportedly were more indiscriminant in their sexual activity: they were more

likely to engage in both homosexual and heterosexual activities, whereas the adolescents with normal intellectual functioning were more likely to engage exclusively in either heterosexual or homosexual activity.

Analysis of offense patterns in the intellectually normal and mentally retarded groups revealed that both groups engaged in both consensual sexual behavior and assaultive and other inappropriate sexual behaviors. Adolescents with mental retardation, however, had a higher rate of sexual assaults against peers and were less likely to know their victims. Adolescents with normal intellectual functioning selected female victims more often, whereas those with mental retardation were equally likely to select male and female victims.

The Gilby, Wolf, and Goldberg (1989) study is informative. Additional research is needed, however, to determine whether the findings in this study can be generalized to other juveniles with mental retardation who have committed sex offenses.

Likelihood of being sexually victimized may be a special issue among juveniles with mental retardation and other developmental disabilities. Cowardin (as cited in Stermac and Sheridan, 1993) reported that developmentally disabled persons are four times more likely than nondisabled individuals to be sexually abused. Also, individuals with developmental disabilities usually are not encouraged to date and marry or to express their sexual needs (Brantlinger, as cited in Stermac and Sheridan, 1993) and typically are relatively uneducated about sexual matters (Edmondson, McCombs, and Wish, as cited in Stermac and Sheridan, 1993).

Juveniles Who Have Committed Sex Offenses Versus Other Types of Offenses

Given limited resources (funding and availability of treatment programs and providers) and reported similarities between juvenile sex offenders and other juvenile delinquents, the question arises as to how extensive the differences are between individual sex offenders and between sex offenders as a group and other juveniles who have been abused and traumatized and have had very difficult lives. Are juveniles who have committed sex offenses a distinct group in need of specialized intervention, or can their needs be best met through interventions that are effective with juveniles who have committed other types of offenses?

Again, research is limited. Available studies, however, suggest that juveniles who commit sex offenses and juveniles who commit other types of offenses share many characteristics (e.g., Miner and Crimmins, 1995).

Milloy (1994) conducted a comparative study of 59 juvenile sex offenders and 132 other juvenile offenders as part of a needs assessment survey. She found that although the juvenile sex offenders had some unique characteristics, they shared many more characteristics with juveniles whose offenses were nonsexual. In contrast to the juveniles whose offenses were nonsexual, the sex offenders were more likely to have been victims of sexual abuse, have major mental health problems, need health or dental hygiene education, lack appropriate peer relationships, and have problems with sexual identity. They also tended to have more adequate academic performance, fewer prior offenses and convictions, and less substance abuse. None of the sex offenders was convicted of a new sex offense. Their overall recidivism rate was lower than that of other offenders. When they did reoffend, their crimes tended to be nonsexual and nonviolent. By the end of a 3-year followup period, only 22 percent of the sex offenders had offense histories limited to sex offenses only. Only 15 percent had been adjudicated for multiple separate incidents of sex offenses. In contrast, 78 percent had been convicted of both sex offenses and other types of offenses. Milloy noted, "These findings suggest that when a longitudinal perspective is used, sex offending among juveniles appears to be but one piece of a pattern of generalized delinquency" (p. 9).

Miner and Crimmins (1995) compared juveniles in juvenile sex offender treatment programs with juveniles who self-reported committing other types of offenses and juveniles who reported no delinquent behaviors in a national survey of juveniles. Few differences were found in the delinquency-related

attitudes of sex offenders and other offenders (e.g., whether it is okay to cheat on tests, be truant, use drugs, be violent, and commit theft). The sex offenders differed, however, from the other offenders in their overall negative attitude regarding most types of delinquent behavior. They also were more disengaged from family interactions. The authors proposed that it may be their social isolation from peers and family that allows juvenile sex offenders to violate a generally prosocial belief system and behave in antisocial ways toward others.

A more recent study by Spaccarelli et al. (1997) further supports findings suggesting that many juvenile sex offenders also commit other types of offenses and are difficult to distinguish from delinquents with no known history of sexual assault. Spaccarelli et al. examined a sample of 210 chronic delinquents, 24 of whom had been arrested for a sex offense and 26 of whom self-reported committing sex offenses for which they had never been arrested. There were no differences on any of the measured variables between the combined group of 50 juvenile sex offenders and a group of 106 juveniles who had been arrested for violent but nonsexual offenses.

Assessment

Clinical Assessment

In view of the heterogeneous nature of juveniles who have sexually offended, comprehensive assessments of individuals are needed to facilitate treatment and intervention strategies. This includes assessment of each juvenile's needs (psychological, social, cognitive, and medical), family relationships, risk factors, and risk management possibilities. To emphasize this point, Dougher (1995) began his chapter describing the process of assessing sex offenders with the subtitle "Comprehensive, In-Depth Assessment Is Prelude to Effective Treatment Planning and Implementation" and pointed out that the literature emphasizes the varied, complex, and multidetermined nature of sex offending. Dougher further emphasized that "[a]ccordingly, any attempt to explain or treat sexually offensive behavior must consider the specific factors pertinent to an individual's offense and the psychological characteristics of the individual offender" (p. 11.2). He added that because many, ". . . if not most, sex offenders tend to lie about their offenses and are unreliable and deceptive in their verbal reports, the value of a thorough assessment cannot be overemphasized" (p. 11.2).

Gathering Multiple Sources of Information

Morenz and Becker (1995) noted that parents or guardians of juveniles should be involved in the assessment and in the treatment process. Informed consent should be obtained from the juvenile and parent or guardian, and they should be clearly informed of the limits of confidentiality (Becker and Hunter, 1997).

Recommended procedures for comprehensive assessment of juveniles who commit sex offenses include clinical interviews with the juveniles and family members, psychological assessment, and, in certain cases (according to some), phallometric assessment (Bonner et al., 1998; Morenz and Becker, 1995). Structured clinical interviews (Morenz and Becker, 1995) and paper-and-pencil psychometric tests and questionnaires (Becker and Kaplan, 1993) also can be useful for assessing pertinent areas that may be related to sex offending, such as attitudes and values, social skills, psychological functioning, and sexual knowledge.

Becker and Hunter (1997) also noted that evaluators should review victim statements, juvenile court records, mental health reports, and school records as part of their assessments. Kraemer, Spielman, and Salisbury (1995) suggested that assessments should address the juvenile's beliefs regarding the sex-offending behaviors; issues of aggression, impulsivity, withdrawal, and depression; attitudes toward treatment; potential barriers to treatment; and approaches most likely to be effective. They also noted that objective measures to assess the prognosis for treatment outcomes are useful, citing as an example personality tests, which can help to identify individuals who are unlikely to succeed in treatment.

Using Psychological Tests

Psychological testing of sex offenders has a long history. Although not all of that history is positive, psychological testing is an important part of a comprehensive assessment (Dougher, 1995). In the past, testing was primarily used for identifying personality characteristics and psychological profiles of offenders; due to the heterogeneity of sex offenders, such attempts were not very successful. As Dougher pointed out, "Nevertheless, psychological tests can be useful in combination with other assessment

procedures to create a clinical picture of an offender and to identify target areas for clinical interventions" (p. 11.7). In fact, psychological tests have been described as adding a "critical dimension" to comprehensive evaluations of juveniles who have sexually offended (Kraemer, Spielman, and Salisbury, 1995). What they add is "a norm-based reference that can assist in determining placement in an appropriate treatment modality, developing a viable treatment plan, and assessing treatment progress" (p. 11.2).

Bourke and Donohue (1996), in their article "Assessment and Treatment of Juvenile Sex Offenders: An Empirical Review," also observed that studies consistently reveal juvenile sex offenders to be a heterogeneous population. For example, they cited research findings that juvenile sex offending coexists with diagnoses of conduct disorders, attention deficit/hyperactivity disorders, antisocial personality disorders, narcissistic personality disorders, learning disabilities, affective disorders, posttraumatic stress disorders, and substance abuse. They concluded, "The high rate of comorbid diagnoses found within this population emphasizes the importance of utilizing sensitive, comprehensive, standardized methods when assessing and treating JSOs [juvenile sex offenders]" (p. 50).

Kraemer, Spielman, and Salisbury (1995) described four primary domains that require assessment: intellectual and neurological, personality functioning and psychopathology, behavioral, and sexual deviance. In addition, Becker and Hunter (1997) pointed out that psychometric testing to assess intellectual functioning and reading ability is important to ensure that the juvenile is able to understand both paper-and-pencil tests and treatment experiences.

The Minnesota Multiphasic Personality Inventory-Adolescent (MMPI–A) has been described as the psychological test most widely used with juvenile sex offenders (Bourke and Donohue, 1996). Because of the heterogeneity of juveniles who have committed sex offenses, there is no MMPI sex offender profile that distinguishes these juveniles from others (Bourke and Donohue, 1996; Dougher, 1995). The MMPI–A's strengths include its validity scales, which help the evaluator assess a juvenile's attitude and approach to the evaluation. As Dougher pointed out, "The extent to which an offender is dishonest, defensive, or malingering has obvious implications for treatment amenability and prognosis" (p. 11.8). The MMPI–A also may be useful for gaining insight into a juvenile's personality and for assessing possible psychopathology (Bourke and Donohue, 1996; Dougher, 1995).

Bourke and Donohue (1996) also reviewed other psychological tests that have psychometric properties and that may be useful for identifying clinical issues and psychopathology relevant to the treatment of juvenile sex offenders. For example, the Multiphasic Sex Inventory (MSI) is an assessment instrument that is used with adult sex offenders to evaluate issues such as sexual interests, knowledge, fantasies, and behaviors. Bourke and Donohue expressed concern that only limited research has been conducted with the MSI; however, their review pertained to a 1984 version of the instrument. There is a juvenile version of the MSI, but it appears that even less research has been conducted with it than with the adult version. In their discussion of the adult MSI, Milner and Murphy (1995) also addressed the issue of limited validity data but stated that in spite of this important weakness, the MSI may have clinical utility for descriptive purposes in known offender groups. Milner and Murphy did not discuss the juvenile MSI.

A more comprehensive and promising approach involves computerized assessment with the Multidimensional Assessment of Sex and Aggression (MASA). The MASA, developed by Dr. Ray Knight, Dr. Robert Prentky, David Cerce, and Alison Martino, is a computerized, self-report inventory that covers multiple domains (Knight and Cerce, 1999; Knight, Prentky, and Cerce, 1994; Prentky and Edmunds, 1997). A juvenile version is currently being validated (R.A. Knight, personal communication, October 16, 2000). The questionnaire asks about attitudes and behaviors in many areas of an individual's life, including childhood experiences, family and social relationships, school and work experiences, alcohol and drug use, and sexual and aggressive behavior and fantasies. The questionnaire includes items that have been associated with different classifications of offenders and with recidivism and includes sophisticated methods for assessing response biases, random responding, and dissimulation.

Studies have demonstrated that psychopathy is a strong predictor of violent behavior in general among adult offenders (e.g., Harris, Rice, and Quinsey, 1993; Quinsey, Rice, and Harris, 1995; Salekin, Rogers, and Sewell, 1996; Serin, 1996) and juvenile offenders (Forth, Hart, and Hare, 1990; Hare, 1991; Forth and Burke, 1998). Studies also have documented an association between psychopathy and sexual violence among adult offenders (Quinsey, Rice, and Harris, 1995; Serin et al., 1994). Studies investigating psychopathy and juvenile sex offending are more limited.

Gretton et al. (as cited in Forth and Burke, 1998) found that adolescent sex offenders who were diagnosed as psychopathic used more threats and more severe violence during their sex offense than those adolescent sex offenders who were classified as nonpsychopathic. Although relatively small proportions of adult sex offenders have been found to be psychopathic (Serin et al., 1994), adult sex offenders who are diagnosed with psychopathy and phallometrically assessed sexual deviance have been described as particularly dangerous (Hare, 1996).

Most studies of psychopathy use the Psychopathy Check List-Revised, a reliable and valid psychometric instrument specifically designed to assess psychopathy. Publication of the juvenile version of the Psychopathy Check List is expected soon (Forth, Kosson, and Hare, in press).

Assessing Deviant Sexual Arousal

To adequately assess individuals who appear to evidence deviant arousal, Weinrott (1998a) stressed the importance of using direct measurement of an individual's sexual arousal, through phallometric assessment (penile plethysmography). Becker et al. (as cited in Becker and Kaplan, 1993) reported preliminary research findings involving phallometric assessment that suggested deviant erectile responding was common in adolescents who had abused young boys and who had been sexually abused themselves.

Others, however, have discussed potential ethical concerns related to using phallometry with juveniles who have committed sex offenses (Bourke and Donohue, 1996; Cellini, 1995). Concerns include the invasive nature of phallometric assessment, possible exposure of juveniles to sexual material beyond their experience, and limited research documenting the validity of phallometric assessment with juveniles. The limited research regarding the utility of phallometric assessment with juveniles who have committed sex offenses is partly due to ethical issues related to obtaining control groups. Weinrott (1998a) noted, however, that many of these issues could be addressed by using stimuli that are less sexually explicit in detail and language, because adolescents typically have strong responses to most sexually explicit stimuli. In addition, less explicit stimuli may increase the validity of phallometric assessment with juveniles.

Another psychophysiological assessment measure used with juveniles who have sexually offended is the Abel Assessment for Interest in Paraphilias (Abel Screening, Inc., 1996). The Abel Assessment is a computer-driven assessment approach that provides an evaluation of a juvenile's sexual interest patterns based on his or her reaction times when viewing slides of potentially sexually evocative stimuli. This methodology is significantly less invasive than phallometric assessment. Good reliability and significant correlations with diagnoses and self-reported arousal patterns have been reported (Abel Screening, Inc., 1996). However, an independent study of the Abel Assessment's reliability and validity raised questions about the use of this assessment approach with juveniles at this time (Smith and Fischer, 1999). The Abel Assessment is relatively new, and additional independent, published research is needed.

Using Other Assessment Strategies

Substance abuse assessment. In addition to the assessment of personality functioning and deviant arousal, it is also important to assess whether the individual has a substance abuse problem and, if so, whether it is a risk factor for that individual's sex offending. The importance of using valid and reliable assessment tools to screen for substance abuse difficulties has been emphasized (Becker and Hunter, 1997; Lightfoot and Barbaree, 1993).

Polygraph tests. Although controversial, the use of polygraph tests in treatment programs for juveniles who have been sexually abusive is increasing (National Adolescent Perpetrator Network [NAPN], 1993). The polygraph is used with some juveniles to facilitate more complete disclosures of sexually abusive behaviors and to monitor compliance with treatment. The National Task Force on Juvenile Sexual Offending noted that "[i]t is critical that submissions to polygraph examinations be voluntary and with full informed consent of the youth, parent, or guardian" (NAPN, 1993, p. 85). When disclosures during polygraph testing reveal previously unreported information, additional investigations can result. Furthermore, the Task Force pointed out that some professional organizations' ethical requirements preclude the use of instruments without empirical evidence of reliability and validity. Research regarding the reliability and validity of the polygraph for assessing juvenile sex offenders is very limited (Hunter and Lexier, 1998). Some researchers have seriously questioned the validity of the polygraph (Cross and Saxe, as cited in Bonner et al., 1998; Saxe, Dougherty, and Cross, as cited in Bonner et al., 1998). Both false positives and false negatives occur, and the emotional impact of polygraph administration on juveniles and the resulting effects on the therapeutic process remain unknown (Hunter and Lexier, 1998).

Risk Assessment

Few empirical studies have investigated sexual reoffense rates among juveniles or risk factors associated with recidivism. Two retrospective studies that investigated the frequency of offenses prior to the referral offense found relatively high offense rates. Awad and Saunders (1991) investigated the sex offense histories of 49 juveniles who sexually assaulted peer or adult females and 45 juveniles who sexually abused younger children. They reported that 61 percent of those who sexually assaulted peers or adults had histories of prior sex offenses and that 40 percent of those who abused younger children had histories of prior molestation. Fehrenbach et al. (1986) found that 57.6 percent of the 297 juvenile sex offenders in their sample had perpetrated other sex offenses prior to their referral offense.

Rates of Recidivism

One prospective study followed juvenile offenders (19 who had committed sex offenses and 58 who had committed other types of offenses) into adulthood (Rubinstein et al., as cited in Sipe, Jensen, and Everett, 1998). Findings revealed that 37 percent of those who had committed sex offenses as juveniles went on to have criminal records for sexual assaults as adults, in contrast to 10 percent of those who had committed other types of offenses as juveniles. A weakness of this study was the relatively small sample size for sex offenders. A strength of the study was its relatively long followup period of 8 years. It may not be possible to generalize the study's findings to other juveniles who have committed sex offenses, not only because the sample of sex offenders was small but also because it included juveniles described as very assaultive (a trait not representative of many juvenile sex offenders).

In contrast to the Rubinstein et al. study (as cited in Sipe, Jensen, and Everett, 1998), most studies have suggested that once a juvenile's sex offending has been officially recognized, subsequent detected sexual recidivism is relatively infrequent (Bremer, 1992; Hagan, King, and Patros, as cited in Kramer et al., 1997; Kramer et al., 1997; Miner, Siekert, and Ackland, 1997; Rasmussen, 1999; Sipe, Jensen, and Everett, 1998; Weinrott, 1996). Sipe, Jensen, and Everett (1998) found that only 9.7 percent of their sample of 124 juveniles who had committed "nonviolent" sex offenses against children under 16 years old were subsequently arrested for a sex offense as an adult. Interestingly, 3 percent of a sample who had committed nonsexual offenses as juveniles were also arrested for a sex offense as an adult. Both groups were more likely to be arrested for nonsexual offenses as adults (16.1 percent of the juvenile sex offenders and 32.6 percent of the other juvenile offenders). Followup periods in the study ranged from 1 to 14 years, with an average of 6 years.

Smith and Monastersky (1986) examined the juvenile justice records of 112 juvenile sex offenders. During a 17-month period of time when they had the opportunity to commit an offense while in the community, 16 (14.3 percent) committed another sex offense and 39 (34.8 percent) committed a nonsexual offense.

Schram, Milloy, and Rowe (1991) followed 197 juvenile sex offenders after they completed 1 of 10 different treatment programs. The followup period ranged from 2 to 7 years. The study found that 37 percent had no new arrests. Of the 63 percent who had new arrests, only 12 percent were arrested for a sexual offense. Similarly, relatively few were subsequently arrested for violent felonies (15 percent). Most rearrests were for either nonviolent felonies (40 percent) or misdemeanors (53 percent). (The offense categories were not mutually exclusive, and the juveniles may have been rearrested for more than one type of offense.) The 2 years immediately following discharge from treatment represented the period of highest risk, especially for those treated in institutions. Although some of the juveniles may have offended later, results suggested that most reoffending occurred when the subjects studied were still juveniles. A very small subset of offenders (seven, or 4 percent of the sample) were deemed, for the purpose of the study, to be "chronic" offenders (defined as having two or more sex offense arrests after the referral offense or one prior and one subsequent sex offense arrest). The researchers found that most of the juveniles in their sample desisted from sex offending after their first sex offense arrest, adjudication, and treatment. They concluded that very few who commit sex offenses as juveniles go on to commit such offenses as young adults. This finding is consistent with that of Sipe, Jensen, and Everett (1998), who, as noted above, found that only 9.7 percent of their juvenile sex offender sample were arrested for sex offenses as adults.

Kahn and Chambers (1991) described 221 juvenile sex offenders identified by Schram and Rowe (as cited in Kahn and Chambers, 1991), who only included 197 in the study reported above (Schram, Milloy, and Rowe, 1991). The subjects in this sample were in the community with the opportunity to reoffend for an average time of 20.4 months. Not surprisingly, recidivism rates were similar to those found by Schram, Milloy, and Rowe (1991). Nearly 45 percent of the 221 juveniles in this sample were convicted of one or more subsequent offenses. Of those who recidivated, only 6.6 percent had new convictions for nonsexual violent crimes and only 7.5 percent had convictions for sex crimes.

More recently, Miner, Siekert, and Ackland (1997) followed 96 juveniles who participated in the Minnesota Department of Correction Juvenile Sex Offender Program. The average time at risk for the followup was 19.3 months. During the followup period, 27.2 percent were arrested for a crime that did not involve a person, 10.4 percent were arrested for a new crime against a person, and only 8.3 percent were arrested for a new sex offense.

Rasmussen (1999) also recently reported findings on factors related to recidivism rates among first-time juvenile sex offenders. Rasmussen's results were consistent with previous research in that 54.1 percent (N=92) of the sample committed a new nonsexual offense, whereas only 14.1 percent (N=24) committed a new sex offense. The relatively higher reoffense rates may reflect the comparatively long followup period of 5 years.

Table 2 summarizes results of the recidivism studies reviewed above. Two of the studies included comparison groups of juveniles who apparently committed only nonsexual offenses. As the table indicates, recidivism involving nonsexual offenses was consistently and significantly higher than recidivism involving sex offenses, for both juvenile sex offenders and comparison groups. Weinrott (1996) provided a more extensive review of studies investigating recidivism rates among juvenile sex offenders. The findings summarized herein are consistent with Weinrott's overall findings.

Methodological variations clearly influence recidivism rates (Prentky et al., 1997). These variations include issues such as the definition of recidivism (i.e., a new arrest versus a new adjudication), the adequacy of delinquency or criminal records, and the duration of the followup period (Prentky et al., 2000). Yet, as Weinrott noted:

> What virtually all of the studies show, contrary to popular opinion, is that relatively few JSOs [juvenile sex offenders] are charged with a subsequent sex crime. Whether this is due to deterrence, humiliation, lack of opportunity, clinical treatment, increased surveillance, or inadequate research methodology is difficult to ascertain. (p. 67)

Table 2: Sexual and Nonsexual Recidivism by Juvenile Offenders

Study	Followup Period	Sexual Recidivism		Nonsexual Recidivism	
		Sex Offenders	Other Offenders	Sex Offenders	Other Offenders
Kahn and Chambers, 1991	M: 20 months[a]	8%[b] (*N*=221)[c]			
Miner, Siekert, and Ackland, 1997	M: 19 months[a]	8% (*N*=96)		38% (*N*=96)	
Rasmussen, 1999	M: 5 years[d]	14% (*N*=170)		54% (*N*=170)	
Rubinstein et al., as cited in Sipe, Jensen, and Everett, 1998	M: 8 years[d]	37% (*N*=19)	10% (*N*=58)		
Schram, Milloy, and Rowe, 1991	R: 2–7 years[e]	12% (*N*=197)		15% (violent felonies), 40% (nonviolent felonies), 53% (misdemeanors)[f] (*N*=197)	
Sipe, Jensen, and Everett, 1998	M: 6 years[d] R: 1–14 years[e]	10% (*N*=124)	3% (*N*=132)	16% (*N*=124)	33% (*N*=132)
Smith and Monastersky, 1986	M: 17 months[a]	14% (*N*=112)		35% (*N*=112)	

Notes: [a] M=mean time at risk in the community. [b] Percentages have been rounded off to the nearest whole number. [c] *N*=the total number of subjects in the group sample. [d] M=mean number of months or years followed by the study. [e] R=range. [f] Offense categories were not mutually exclusive, and the juveniles may have been rearrested for more than one type of offense.

Factors Associated With Recidivism

Becker (as cited in Friedrich, 1990) suggested that adolescent sex offenders were probably more likely to reoffend if one or more of the following factors were present: initial offending was pleasurable, consequences for the offense were minimal, the deviant sexual behavior was reinforced through masturbation or fantasy, and/or the offender had social skills deficits. These factors appear to have good face validity but require additional assessment.

As noted above, Smith and Monastersky (1986) examined the juvenile justice records of 112 juvenile sex offenders. They found that very few selected predictor variables were associated with reoffending. Offenders described as having "unhealthy" attitudes regarding sexuality (i.e., those who naively denied normal adolescent sexual behavior) were less likely to reoffend by committing a sex offense and somewhat less likely to reoffend by committing a nonsexual offense. The only other statistically significant findings involved nonsexual reoffenses. Offenders who appeared to understand the exploitive nature of their sex offenses were less likely to reoffend nonsexually, and those who were unable to identify their personal strengths were more likely to reoffend nonsexually. Interestingly, a lack of depression and a willingness to explore the referral sex offense nondefensively were both marginally related to an increased rate of sexual reoffending and a reduced rate of nonsexual reoffending.

In the Smith and Monastersky study, some offense characteristics also were marginally associated with reoffending in general. Rapists were less likely to reoffend than those who committed seemingly less serious crimes. Those who offended against substantially younger victims (*4* or more years younger than the offender) were less likely to reoffend. In contrast, those who committed offenses against strangers were more likely to reoffend sexually (and less likely to reoffend nonsexually) than those who offended against relatives or acquaintances. Lastly, those who had at least one recent offense against boys were described as "somewhat" more likely to reoffend sexually than those who offended only against girls.

Schram, Milloy, and Rowe (1991) found that juvenile sexual recidivists had higher rates of truancy, higher rates of thinking errors (erroneous perceptions, ideas, and beliefs that justify abusive behavior—e.g., blaming victims), and at least one prior sex offense. They also were much more likely to have deviant sexual arousal patterns, although this was not assessed with physiological measures. Sexual recidivism was not related to the type of referral sex offense, treatment location, or type of treatment received.

In Schram, Milloy, and Rowe (1991), those who did not reoffend generally were older, had less previous contact with the juvenile justice system, and were less likely to have school behavior problems or truancy. They also were significantly less likely to have been sexually abused or have a sibling who was abused. They were more likely to have social skills deficits and were significantly less likely to blame their victims or exhibit deviant arousal patterns.

Kahn and Chambers (1991) found (in Schram and Rowe's sample, as cited in Kahn and Chambers, 1991) that only two variables were significantly positively associated with sexual reoffending: using verbal threats during the commission of the offense and blaming the victim for the crime. Surprisingly, denial of the offense was negatively associated with reoffense rates: none of the eight offenders who completely denied their offenses sexually reoffended. Although offenders with "therapist-identified" deviant arousal (i.e., assessed by clinical judgment) reoffended at a higher rate than those without deviant arousal (13 percent versus 6 percent), this difference was not statistically significant. Similarly, although offenders who victimized a child they knew but were not related to were more likely to be adjudicated delinquent for a new sex offense than those who were related to their victims, the difference was not statistically significant. It also is important to note that more than 50 percent of the adolescent sex offenders in this study had histories of nonsexual criminal offenses.

In their 1997 study of juvenile sex offenders, Miner, Siekert, and Ackland indicated that predictors of reoffending included penetrating the victim during the original sex offense and coming from an unstable home. In Rasmussen's 1999 study of juvenile sex offenders, multivariate analyses revealed that sexual recidivism was associated with perpetrating sex offenses against multiple female victims; i.e., juveniles with a history of multiple female victims, as contrasted with a single female victim or multiple male victims, were more likely to sexually reoffend. This finding is contrary to Smith and Monastersky's (1986) finding suggesting that juvenile sex offenders who sexually abused male victims may pose a higher risk of sexual reoffending. In addition, Rasmussen (1999) found that nonsexual recidivism among

juvenile sex offenders was related to having a relatively high rate of previous nonsexual offenses and to not completing treatment.

In spite of the various descriptions of characteristics identified in juveniles who have sexually offended, Weinrott (1998b) reported that very few characteristics have been empirically associated with sexual recidivism. He noted that these characteristics include the following (Weinrott, 1998b, p. 1):

- Psychopathy.
- Deviant arousal.
- Cognitive distortions.
- Truancy.
- A prior (known) sex offense.
- Blaming the victim.
- Use of threat/force.

Weinrott (1998b) reported that in contrast to what has been commonly thought, factors such as denial, abuse histories, and empathy deficits (among others) either have not been empirically associated with sexual recidivism (i.e., have not statistically accounted for significant variance in outcomes) or have simply not been investigated.[6] This is not to say that interventions designed to address these factors (e.g., efforts to reduce social skills deficits or educate offenders about victim impact) are not effective in reducing sexual recidivism, only that there is no empirical evidence indicating they are effective.

For example, a recent study (Hunter and Figueredo, 1999) found that nearly 75 percent of the juveniles who did not evidence any denial of their sex offenses when beginning treatment successfully complied with treatment requirements during the 12-month period under study. In contrast, only 25 percent of the juveniles who evidenced full denial complied with treatment during the same period. The authors reported that "attitudes of openness and accountability proved to be the best predictors of a positive treatment outcome" (p. 65). It is important to note that adjudication may have been a confounding variable in this study, given that most of the juveniles who were adjudicated completely acknowledged their offense and relatively few of those who had not been adjudicated did so. Thus, the adjudication process and its consequences may have contributed significantly to treatment compliance. Furthermore, this study did not investigate whether openness and accountability were related to reduced recidivism rates.

Prediction of Recidivism

In a recent commentary, Chaffin and Bonner (1998) pointed out that there are no true experimental studies comparing untreated and treated juvenile sex offenders and no prospective studies evaluating risk factors or the natural course of sexual offending. As noted above, empirically based typologies have received some attention; however, an actuarial risk assessment schedule with adequate empirical validation is lacking (NAPN, 1993).

Two studies have investigated the accuracy of recidivism predictions by program staff. Schram, Milloy, and Rowe (1991) found that treatment staff members very accurately identified offenders who presented a low risk for sexual reoffending, but some of these juveniles reoffended in other ways. In contrast, only 18 percent of juveniles who were identified by program staff as "at risk" or "dangerous" sexually reoffended during the period under study. It is possible, of course, that some of these at-risk or dangerous offenders actually reoffended but were not detected. This finding is consistent with others (e.g., Smith and Monastersky, 1986) and suggests that treatment providers may tend to overpredict sexual recidivism (and therefore keep offenders in treatment) rather than risk the dire consequences associated with failing to predict recidivism that comes to pass.

There are a number of explanations for the relatively poor accuracy of attempts to predict sexual (and violent) recidivism (Smith and Monastersky, 1986).

[6] Weinrott (1998b) listed the following factors as lacking empirical evidence: "(a) denial of offense or sexual intent, (b) low motivation for treatment, (c) introversive or antisocial personality traits, (d) low intelligence, (e) social-skills deficits, (f) impulsiveness, (g) pornography use, (h) conduct disorder, (i) abuse history, (j) minority race, (k) family relationships/structure, (l) delinquency, (m) alcohol/drug abuse, (n) lack of empathy, and (o) length and type of treatment" (p. 1).

Sex offending is a relatively infrequent event. Predicting any low-frequency event is difficult. The hidden nature of sexual abuse may contribute to low reoffense rates because reoffending may tend to go undetected; however, juveniles who have already been identified as sex offenders may be followed more closely and have less opportunity to reoffend. Too short followup periods also may account for low predictive accuracy; some offenders may offend sometime in the future, but after the study period. Further, as Smith and Monastersky observed, "It may be that the low rate of sexual reoffending is due to lasting changes in the offender and/or his family as a result of being identified, evaluated, treated, adjudicated, and/or sentenced" (p. 135).

Other problems associated with poor predictive accuracy include the absence of pertinent information needed for decisionmaking and clinicians' overreliance on inadequate predictors (MacArthur Violence Risk Assessment Study, 1996). An additional confounding factor is conservative decisionmaking that occurs to avoid predicting that someone will not reoffend, when in fact they might (Smith and Monastersky, 1986). As researchers have noted (Smith and Monastersky; Webster et al., 1997), to enhance predictive accuracy, professionals should balance historical and actuarial information with clinical and situational information. Assessment of risk should address a variety of factors that pertain to the individual juvenile and the juvenile's environment and situational factors that could increase or reduce risk.

Ageton and her colleagues (as cited in Prentky et al., 2000) investigated the predictive utility of several measures and found that four variables correctly classified 77 percent of the juveniles who reoffended sexually: involvement with delinquent peers, history of crimes against persons, attitudes toward rape and sexual assault, and family normlessness. Subsequent analysis revealed that only one variable—involvement with delinquent peers—was necessary to correctly classify 76 percent of the cases.

Prentky et al. (2000) have developed and conducted initial testing of an actuarial risk assessment schedule designed to assess the risk of reoffending among juvenile sex offenders. The schedule includes four factors: sexual drive/preoccupation, impulsive/antisocial, clinical/treatment, and community adjustment. The factors and individual items are based on literature reviews of studies pertaining to juvenile sex offenders, adult sex offenders, and juvenile delinquents in general. The risk assessment schedule was evaluated by following 96 juvenile sex offenders who had received treatment on an outpatient basis. The followup period was 12 months. Only 11 percent of the offenders who were studied committed any type of criminal offense during the followup period, and only three of these juveniles (4 percent of the sample) committed another sex offense. In evaluating the validity of the risk assessment schedule, Prentky et al. reported that, overall, the interrater reliabilities for the items (which indicate consistency in scoring between individual raters) were good to excellent and the scale alphas (which provide a conservative estimate of a measure's reliability) were quite good. Because of the very low base rate of sexual recidivism, the researchers were unable to evaluate predictive validity. Overall, however, the findings were encouraging. Data collection continues at a number of different sites to gather sufficient cases to permit a proper look at the usefulness of the schedule for assessing risk and predicting reoffending.

As Epps (1994) noted, potential problems in using risk assessment tools to predict juvenile sex offenders' likelihood of reoffending include difficulties in gathering reliable and valid information on which to base such instruments. Sufficient staff training and supervision also are important to ensure appropriate and reliable risk assessment.

Treatment

The National Task Force on Juvenile Sexual Offending consists of 20 members and 20 advisory members (NAPN, 1993). The Task Force was formed in 1986 after National Adolescent Perpetrator Network (NAPN) members (treatment providers and intervention specialists from more than 800 programs) supported the idea of creating a group to develop standards for the assessment and treatment of juvenile sex offenders. Recognizing that sufficient research did not yet exist to warrant a presentation of intervention standards, the National Task Force (as cited in NAPN) articulated a set of assumptions intended to reflect the current thinking relevant to a comprehensive systems response to juveniles who have sexually offended. These assumptions are summarized below.

- Following a full assessment of the juvenile's risk factors and needs, individualized and developmentally sensitive interventions are required.
- Individualized treatment plans should be designed and periodically reassessed and revised. Plans should specify treatment needs, treatment objectives, and required interventions.
- Treatment should be provided in the least restrictive environment necessary for community protection. Treatment efforts also should involve the least intrusive methods that can be expected to accomplish treatment objectives.
- Written progress reports should be issued to the agency that has mandated treatment and should be discussed with the juvenile and parents. Progress "must be based on specific measurable objectives, observable changes, and demonstrated ability to apply changes in current situations" (NAPN, 1993, p. 53).
- Although adequate outcome data are lacking, NAPN (1993) suggests that satisfactory treatment will require a minimum of 12 to 24 months.

Some individual States also have worked to develop appropriate protocols and standards for effective interventions with juveniles who have committed sex offenses. For example, Utah established a multidisciplinary team of professionals who developed a manual establishing guidelines for treatment and service delivery (Utah Task Force of the Utah Network on Juveniles Offending Sexually [Utah NOJOS], 1996).

Treatment programs for juvenile sex offenders have proliferated during the past decade. According to NAPN (1988), there were only 20 such programs in the United States in 1982. The 1994 Safer Society Program's national survey (Freeman-Longo et al.) identified 684 programs.

Continuum of Care Models

To adequately address both the needs of individual juveniles who have committed sex offenses and the needs of the community, a continuum of care is recommended (Bengis, 1997; NAPN, 1993). Offering a range of interventions and placement options makes it possible to provide cost-effective interventions while placing paramount importance on community safety. Such a continuum, as described in the *Oregon Report on Juvenile Sex Offenders* (Avalon Associates, 1986), may include:

- Short-term, specialized psychoeducational programs.
- Community-based outpatient sex offender treatment programs for juveniles remaining at home or in foster care.

- Day treatment programs.
- Residential group homes or residential facilities.
- Training schools for short-term placements providing assessments and facilitating readiness for community-based treatment.
- Secure units providing comprehensive, intensive treatment, including daily unit groups; two to three small daily groups focusing on interpersonal skills; weekly sessions on a variety of topics, such as sex offending issues, stress cycles, anger management, and social skills; parent groups; family therapy; individual treatment; substance abuse therapy, if needed; and more.

The *Oregon Report* recommended individualized assessments, although the comprehensiveness of the assessments might vary depending on individual needs. Such assessments guide appropriate placement along the continuum of care and also guide individualized interventions and treatment.

Bengis (1997) also described a comprehensive continuum of care with similar components, such as:

- Locked residential treatment facilities.
- Unlocked residential treatment units made secure by staff.
- Alternative community-based living environments, such as foster care, group living homes, mentor programs, or supervised apartments.
- Outpatient groups, day programs, and special education schools.
- Diagnostic centers and services specifically designed to provide assessments tailored to sex offenders in addition to traditional diagnostic assessments.

Bengis (1997) pointed out that at different points during their treatment, juveniles may require different levels of supervision and treatment intensity. He stressed that to be most effective, the components of the continuum should have consistent treatment philosophies and approaches and, whenever possible, should provide stability in treatment providers as the juvenile moves along the continuum.

The Utah Task Force (Utah NOJOS, 1996) also recommended a continuum of care. In addition to the placements described above, the task force included inpatient assessment and stabilization and psychiatric treatment. It described a continuum for both adolescents and preadolescent children.

Treatment Approaches

Overview

The NAPN (1993) stressed that the primary objective of interventions with juveniles who have sexually offended is community safety. Cellini (1995) described the primary goals of treatment interventions with these juveniles as helping them to gain control over their sexually abusive behaviors and to increase their prosocial interactions with peers and adults. Similarly, Becker and Hunter (1997) described the main treatment objectives as preventing further victimization, halting the development of additional psychosexual problems, and helping the juvenile develop age-appropriate relationships with peers.

To accomplish these goals, highly structured interventions, frequently involving written treatment contracts, are recommended (Morenz and Becker, 1995). Treatment approaches include individual, group, and family interventions. Although group therapies often are described as the treatment of choice (NAPN, 1993), empirical support for this claim is lacking (NAPN, 1993; Weinrott, 1996). Similarly, cotherapy teams, preferably involving a female therapist and a male therapist, also are recommended (NAPN, 1993), but the necessity of such teams has not been demonstrated.

As Marshall and Barbaree (1990) noted in their review of the effectiveness of adult cognitive-behavioral sex offender treatment programs, most cognitive-behavioral programs combine individual treatment approaches with group therapy. Individual treatment typically addresses sexual preference interventions and some aspects of social functioning. Marshall and Barbaree pointed out, however, that individual therapy is expensive and often is not cost effective. Group therapy can be a more efficient means of concurrently presenting the

educational components of treatment to a number of offenders. Furthermore, male-female therapist teams can model egalitarian relationships between the sexes for group members, and group members may be able to draw on their own experiences as offenders to provide valuable insights into other offenders' difficulties. Marshall and Barbaree also noted that group processes can facilitate new ways of thinking and social interaction that are unavailable in "traditional individualized treatment." On the other hand, the potential advantages of group therapies must be weighed against the possible disadvantages related to negative peer group associations, as have been identified in the juvenile justice field (e.g., Fagan and Wexler, as cited in Henggeler, Melton, and Smith, 1992).

The first step in treatment typically involves helping the juvenile accept responsibility for his or her behavior (Becker and Hunter, 1997). A number of factors (e.g., legal defense strategies and parental disbelief), however, can make this a difficult task. Minimizing and denying abusive behavior are common responses and are typically viewed as problematic (NAPN, 1993). Barbaree and Cortoni (1993) noted that denial is so often considered such an obstacle to effective treatment that many programs will not accept individuals who are unremitting in their denial. Barbaree and Cortoni also observed, however, that once the juvenile sex offender's denial and minimization are reduced, the offender can begin to empathize with the victim. Barbaree and Cortoni consider the reduction of denial and minimization and the development of empathy with the victim to be the necessary "first step" in facilitating the offender's motivation for treatment and behavior change.

Recommended treatment content areas for juveniles who have sexually offended typically include sex education, correction of cognitive distortions (cognitive restructuring), empathy training, clarification of values concerning abusive versus nonabusive sexual behavior, anger management, strategies to enhance impulse control and facilitate good judgment, social skills training, reduction of deviant arousal, and relapse prevention (Becker and Hunter, 1997; Hunter and Figueredo, 1999; NAPN, 1993). Other relevant interventions include training in vocational and basic living skills, assistance with academics, resolution of personal victimization experiences, assistance with coexisting disorders or difficulties, resolution of family dysfunction and impaired sibling relationships, and development of prosocial relationships with peers, dating skills, and a positive sexual identity (Becker and Hunter, 1997; Hunter and Figueredo, 1999; NAPN, 1993). Research comparing adolescent sex offenders with a group of runaways found that the former were especially deficient in their general knowledge about AIDS and safe sex practices (Rotheram-Borus, Becker, Koopman, and Kaplan, as cited in Becker and Kaplan, 1993). Given this finding, the importance of focusing treatment on sexually transmitted diseases and safe sex is obvious.

Goocher (1994) noted that leaders in the field of juvenile sex offender treatment, such as Judith Becker and John Hunter, have argued that programs designed to focus exclusively on sex-offending behaviors are of limited value and have recommended a more holistic approach. Goocher further pointed out that, in view of the individual needs and developmental histories of these juveniles, "quasi-corrections models" of addressing sex offending are not adequate. Goocher noted that many residential treatment programs for juvenile sex offenders have been based on quasi-corrections models of treatment adapted from work with adult sex offenders. Goocher also observed how, in one program, staff seemed to replicate the juveniles' power and control behaviors and secretive behavior in the staff's own interactions among themselves and in their interactions with the institution's managers, with other units, and with the juveniles. He recommended that the staff in such programs be sensitive to their positions as role models and guides for juveniles who are attempting to move beyond their life experiences and offense histories and that staff receive adequate training to enable them to perform this function.

Miner and Crimmins (1995) identified social isolation from positive interactions with peers and families as a possible factor that may explain why some seemingly prosocial juveniles engage in sexually aggressive acts. They suggested that treatment efforts should break the process of social isolation and noted that most programs do this through group

and social-cognitive interventions. They further recommended family interventions and facilitation of positive school attachments and positive emotional attachments in general as treatment goals.

Weinrott (1998a) noted that some treatments that are theoretically sound but have not been empirically related to sexual recidivism may also be appropriate for juvenile sex offenders. For example, Weinrott, noting that truancy is empirically associated with sexual recidivism, recommended that treatment actively target improved school performance. In addition, because appropriate and effective dating skills can increase access to appropriate sexual partners, Weinrott and others (e.g., Bourke and Donohue, 1996) emphasized development of dating skills as a treatment component. Weinrott also encouraged more aggressive interviewing techniques, such as interrogation approaches used by law enforcement, to get through denial quickly so that treatment can proceed in a more timely fashion.

Although psychopharmacological interventions, including sex-drive reducing medications such as medroxyprogesterone, have been found to be effective in reducing sex offending in adult offenders, they can have serious side effects. Such medications, when used with juveniles, can have possible negative effects on normal development and growth. Consequently, ethical concerns related to the use of these medications with juveniles are substantial (Hunter and Lexier, 1998).

Other medications sometimes are used with juveniles as part of a comprehensive treatment approach. For example, Hunter and Lexier (1998) noted reports from the professional literature that describe the utility of selective serotonin reuptake inhibitors (SSRI's). Lane (as cited in Hunter and Lexier, 1998) reported that SSRI's often have sexual dysfunction side effects such as suppressed sexual desire and delayed ejaculation. However, as Hunter and Lexier noted, the role of serotonin in regulating sexual behavior is not fully understood. Many questions concerning psychopharmacological approaches remain. These questions include which juveniles are likely to benefit from such an approach and at what dosages (Hunter and Lexier, 1998).

Addressing Deviant Arousal

Weinrott (1998a) stressed that juvenile sex offenders with deviant sexual arousal should be provided with treatment that effectively addresses this problem. Most programs that address deviant arousal do so through covert sensitization, a treatment approach that teaches juveniles to interrupt thoughts associated with sex offending by thinking of negative consequences associated with abusive behavior (Becker and Kaplan, 1993; Freeman-Longo et al., 1994). Weinrott raised the concern that this technique, as typically used, may not be vivid enough to be effective for adolescents who might not have the language abilities to design effective fantasies to counter deviant thoughts or who may simply find the task too boring. He also stated that behavioral conditioning with noxious stimuli, such as ammonia and, possibly, low-intensity electric shock, may be effective. The National Task Force on Juvenile Sexual Offending, however, advised that use of aversive therapies with juveniles is controversial (NAPN, 1993). It recommended that, when used, aversive stimuli should be self-administered by the juvenile, with appropriate consent from the juvenile, parent, and referring authority. Although the National Task Force advised against electric shock, it did not elaborate as to why adequate safeguards cannot be effectively applied.

Some treatment approaches that have been used with sex offenders, such as masturbatory satiation, are designed to render deviant fantasies or thoughts boring through repetition (Becker and Kaplan, 1993). Masturbatory conditioning, however, has presented practical as well as ethical concerns, because the approach requires asking the juvenile to masturbate, and may include masturbating to deviant stimuli with the goal of ultimately reducing such arousal (Becker and Kaplan, 1993; Bourke and Donohue, 1996; Morenz and Becker, 1995). Furthermore, as Hunter and Lexier (1998) observed, empirical findings concerning the effectiveness of any arousal conditioning approach are confounded by the inclusion of these approaches as part of a comprehensive treatment program. Consequently, Hunter and Lexier concluded that very little is known about the effectiveness of these approaches for reducing deviant arousal or about the types of juveniles for whom they may be most effective.

Vicarious sensitization (VS) is a relatively new treatment technique that may avoid some of the ethical concerns presented by other approaches. VS is a form of aversive conditioning that pairs deviant arousal with negative experiences. It involves exposing the juvenile to audiotaped crime scenarios designed to stimulate arousal and then, immediately afterwards, showing an aversive video that presents the negative social, emotional, physical, and legal consequences of sexually abusive behavior. Weinrott, Riggan, and Frothingham (1997) reported a study comparing a group of juvenile sex offenders who were administered a course of VS with a group who were on a waiting list but who had not yet received VS. Both groups received standard cognitive therapy during the study period. Phallometric assessment and self-report measures at 3 months revealed significantly reduced deviant arousal for the juveniles who had received VS. Furthermore, although the juveniles on the waiting list did not improve during the study period, they evidenced improvement after they received VS treatment. Although noting the limitations of a 3-month followup period, Weinrott and colleagues described VS as a technique that, used in conjunction with specialized cognitive therapy, may be an effective approach for reducing deviant arousal in juveniles who are sexually aroused by prepubescent children. As in all areas of sex offender treatment, additional research is needed to assess the effectiveness of this approach, including its long-term effectiveness.

Involving Families

Rasmussen (1999) argued that adequate family support can help reduce recidivism and that treatment programs that involve families are likely to be more effective than those that do not. As Gray and Pithers (1993) observed, however, families vary in terms of their motivation and ability to effectively facilitate their child's treatment. Gray and Pithers described strategies that can engage the cooperation of family members and reported that parents found the following approaches useful:

> (1) written information on relapse prevention, cognitive distortions, and the consequences of sexual abuse; (2) educational videotapes of adolescent abusers discussing their relapse process and the need to be held accountable; (3) literature on the recovery process of sexual abuse victims; (4) referrals to treatment groups for adult survivors of sexual abuse; (5) the opportunity to be included periodically in sessions of the adolescent abuser group; (6) support groups for parents of abusive adolescents; and (7) attention to the concerns of the juvenile's siblings in the treatment process. (p. 314)

Lee and Olender (1992) described a teaching-family model of community-based residential treatment that has been used with juvenile sex offenders and other children. They noted that this specialized foster care approach can be very restrictive and can provide intensive treatment in a more homelike atmosphere, depending on the program components required for a particular child at a particular time. Through this approach, juveniles receive interventions in a more naturalistic setting, enabling them to acquire and practice prosocial life skills in situations similar to everyday life. The approach focuses directly on behaviors and uses a systematic reward program (a token economy) to enhance positive motivation. It also uses cognitive-behavioral approaches to facilitate behaviors such as impulse control, effective problem solving, moral and ethical decisionmaking, and so on. Foster parents trained to be "teaching parents" use techniques that have been researched and found useful for managing intense and emotionally volatile behaviors, and they use a curriculum to facilitate skills necessary for social competence and independent living. Foster parents are provided with support services, and juveniles participate in group counseling interventions. Lee and Olender reported that initial implementation research, conducted as part of the Ohio Youth Services Network's evaluation of sex offender treatment programs throughout the State, found that the program provided "high quality, appropriate care of adolescent offenders and emotionally disturbed youth" (p. 74). Outcome research is under way.

Using a Relapse Prevention Model

Relapse prevention initially was designed to help substance abusers prevent reoccurrence of substance-abusing behavior. Then Pithers, Marques, Gibat, and Marlatt (as cited in Barbaree and Cortoni, 1993)

applied relapse prevention to adult sex offenders to reduce sexual reoffending. Gray and Pithers (1993) applied relapse prevention to the treatment and supervision of children and adolescents with sexual behavior problems.

Relapse prevention requires that juveniles learn to identify factors associated with an increased risk of sex offending and use strategies to avoid high-risk situations or effectively manage them when they occur. Gray and Pithers (1993) noted, however:

> A high degree of motivation and integrity is required for a client to continually monitor signs of his relapse process and to invoke coping strategies, even when it feels like a sacrifice to do so. Without the dedication derived from the empathy for sexual abuse victims developed in treatment, RP [relapse prevention] risks becoming an intellectual exercise that educates offenders about what they need to do to avoid reoffending but that finds offenders lacking the motivation to use this knowledge. (p. 299)

When relapse prevention is applied to children, greater emphasis is placed on external supervision to prevent further victimization (Gray and Pithers, 1993). The relapse prevention approach is theoretically sound; however, as with other components of treatment for juveniles who have sexually offended, empirical studies investigating the effectiveness of this approach are lacking.

Summary

Some of the interventions described above appear appropriate for some juveniles who have committed sex offenses, but others do not. Furthermore, many of the target areas described above are relevant not only for sex offenders but also for juveniles who commit other types of offenses. In view of the many studies identifying general delinquency and antisocial attitudes and behavior among juveniles who exhibit sexual behavior problems, Weinrott (1998a) suggested that relevant empirically based treatment interventions for juvenile delinquents be used with those who commit sex offenses, whenever the interventions are indicated. Similarly, as Rasmussen (1999) stressed, "Treatment programs should be structured to address the factors that contribute to and maintain *all* criminal behavior, not just sexual offending" (p. 81).

Prentky (1995, 1997) presented potential target areas of treatment for juvenile and adult sex offenders and corresponding modalities for intervention. Although most of the modes of treatment presented by Prentky are discussed in this literature review, a few have not been mentioned, such as childhood victim survivors' group therapy and expressive therapy.

Table 3 provides a guide to treatment intended to reduce offending behaviors. It incorporates Prentky's (1995, 1997) work, treatment and modalities discussed in this literature review, and the authors' clinical understanding of these issues. The table presents clinical interventions but does not cover other strategies such as supporting appropriate academic placements, school attendance, and vocational training. As emphasized throughout this literature review, individualized assessment should guide the development of an appropriate treatment plan for each individual; the information presented in table 3 should not be rigidly applied.

Research on Treatment Efficacy

Specialized Treatment for Juveniles Who Have Committed Sex Offenses

In spite of the proliferation of programs specifically designed for juvenile sex offenders, evaluation of these specialized approaches has been limited. For example, as Weinrott (1996) observed, most sex offender treatment programs have learning about the "sexual assault cycle" at their core. The cycle is used to help juveniles conceptualize their offending behaviors, including the associated feelings and distorted thinking that contribute to and follow their abusive acts. Becker (1998) described the cycle concept that was developed by Ryan, Lane, Davis, and Isaac (as cited in Becker, 1998). The concept is based on the premise that offending is preceded by a negative self-image that contributes to negative coping strategies when the juvenile anticipates negative responses from others, perceives such responses, or both. To avoid such negative anticipated

Table 3: Treatment To Reduce Offending Behaviors

Modes of Treatment	Target Areas of Treatment						
	Impaired Social Relationships	Empathy Deficits	Cognitive Distortions	Deviant Sexual Arousal	Problematic Management of Emotions	Impulsive/ Antisocial Behaviors	Consequences of Personal History of Child Maltreatment
Anger Management	X		X		X		
Assertiveness Training	X				X		
Aversion Therapy				X			
Childhood Victim Survivors' Group	X	X	X		X		X
Cognitive Restructuring	X	X	X		X	X	X
Covert Sensitization				X			
Expressive Therapy		X			X		X
Family Interventions	X	X	X		X	X	X
Group and Individual Therapy	X	X	X	X	X	X	X
Multisystem Interventions (e.g., MST and MTFC)	X	X	X		X	X	X
Pharmacotherapy				X	X	X	
Positive Identification Development	X		X				X
Relapse Prevention and Offense Cycles			X	X	X	X	
Self-Control and Impulse Management				X	X	X	
Self-Help Groups	X					X	X
Sex Education and Dating Skills	X						
Social Skills Training	X						
Stress and Anxiety Management	X				X	X	
Substance Abuse Education and Treatment					X	X	
Systematic Desensitization	X			X			
Vicarious Sensitization				X			
Victim Empathy Training	X	X	X			X	

or perceived reactions, the juvenile withdraws, becomes socially isolated, and fantasizes to compensate for resulting feelings of powerlessness and a lack of control. This process culminates in the sex offense, which results in more negative experiences, more feelings of rejection, and an increasingly negative self-image; and the cycle continues.

Weinrott (1996) pointed out that in spite of the fact that the sexual assault cycle has been used in sex offender treatment for nearly 20 years, this model has not been empirically validated. Furthermore, as Weinrott noted, although the cycle may fit many juveniles who have committed sex offenses, it does not explain the abusive behavior of all such offenders, including those described as "naive experimenters," those who desist from their abusive behavior, those who perpetrate sex offenses as part of a group, and those whose sexual behavior may be a result of significant psychopathology or deviant sexual arousal.

In their editorial, "Don't Shoot, We're Your Children: Have We Gone Too Far in Our Response to Adolescent Sexual Abusers and Children With Sexual Behavior Problems?" Chaffin and Bonner (1998) cautioned against the "conviction" that those working in the field have found the right approach. They wrote that such "dogma" might include the following beliefs:

> That sex offender-specific treatment is the only acceptable and effective approach and that all teens and children who have performed inappropriate sexual behaviors must receive it; that a history of personal victimization is usually present, is a direct cause of abusive sexual behaviors, and must be a focus of treatment; that denial must be broken; that hard, in-your-face confrontation is synonymous with good therapy; that treatment must be long term and involve highly restrictive conditions; that deviant arousal, deviant fantasies, grooming [of victims] and deceit are intrinsic features; that parents and families of offenders are generally dysfunctional; that long-term residential placement is commonly required; that behaviors always involve an offense cycle or pattern that must be identified; that these teenagers and their parents must face the fact that they have a compulsive, incurable, life-long disorder; and that these youngsters are such dangerous predatory criminals that neighborhoods must be notified of their presence. Despite their wide acceptance, it is our opinion that clear, empirical scientific support for each and every one of these conventional wisdoms is either minimal or nonexistent. (p. 314)

Chaffin and Bonner (1998) reported that they knew juveniles who felt required to "confess" to sex offenses they did not commit and to deviant fantasies they did not have, because they thought they would be discharged from the treatment program if they did not comply. The authors also expressed concern that "overly broad applications" of fantasy journals, addiction/compulsion programs, shaming approaches, and programs that aggressively encourage empathy with victims could negatively affect these juveniles. Chaffin and Bonner further pointed out that although rates of detected sexual reoffenses appear relatively low (around 5 to 15 percent), the lack of untreated comparison groups prevents us from knowing whether treatment has been effective. In fact, they stressed, "Empirically, we cannot say whether treatment helps, hurts, or makes no difference" (p. 316). Chaffin and Bonner's views are consistent with Weinrott's (1996), who stated:

> The prevailing view is that early clinical intervention is needed to break the cycle of sexual deviance, and that intervention should take the form of lengthy, offense-specific, peer-group therapy. There is not a shred of scientific evidence to support this stance. (p. 85)

Chaffin and Bonner (1998) and Weinrott (1996) have observed that at this point, it is not possible to say whether one type of treatment is better than another, with the possible exception of delinquency-focused multisystemic treatment, which appears to be more effective than individual counseling with juveniles who have committed sex offenses. Furthermore, as Weinrott noted, there also is no evidence to support a "heavy handed" correctional or justice response.

A study that appears to raise questions about the efficacy of specialized treatment for juveniles who have committed sex offenses was conducted by Lab, Shields, and Schondel (1993). The researchers

compared the recidivism rates for juveniles treated in a specialized sex offender treatment program with rates for juveniles referred to community-based treatment programs generally lacking specialized programs for sex offenders. The study found that recidivism rates for both groups were low and that the outcome for juveniles treated in the sex-offense-specific program was no better than that for those treated in non-offense-specific programs. Like Chaffin and Bonner (1998), Lab, Shields, and Schondel concluded, "These results suggest that the growth of interventions has proceeded without adequate knowledge of how to identify at-risk youth, the causes of the behavior, and the most appropriate treatment for juvenile sex offending" (p. 543). Methodological problems, however, may have compromised the utility of this study (Weinrott, 1996).

In contrast to the Lab, Shields, and Schondel (1993) findings are results from a study by Kimball and Guarino-Ghezzi (1996), who compared 75 juvenile sex offenders treated in sex-offense-specific programs with sex offenders treated in non-offense-specific programs. Although placement in treatment programs was not randomized, juveniles did not vary significantly on their prior record, previous sexual deviance, or exposure to sexual, physical, and substance abuse. Findings revealed that juveniles placed in sex offender treatment demonstrated more positive attitudes and greater skill acquisition than those in nonspecific treatment. They were more likely to accept full responsibility for their offenses, to express remorse related to victim impact, and to articulate practical relapse prevention concepts and strategies. They also were significantly more successful in completing their first aftercare placements (70.6 percent, versus 41.2 percent for nonspecific treatment placements). At the time of this report, followup results were limited to 6 months. Findings suggested that participation in sex offender treatment contributed to lower rates of reoffending.

Although the Kimball and Guarino-Ghezzi (1996) treatment outcome results appear encouraging, these findings are tempered by other findings indicating that participants in the sex offender programs received more treatment than those in nonspecific programs. Those placed in sex-offense-specific treatment programs received significantly more therapy sessions, including group sessions that focused specifically on offending behavior. They also received significantly more family therapy (51.8 percent, versus 30.8 percent for those in nonspecific treatment). In addition, they received more treatment for nonsexual factors contributing to their sex offending; such treatment included family therapy, interpersonal skills training, stress and anxiety management, and relapse prevention. They also remained in treatment for significantly longer periods than those who received nonspecific programming (an average of 15.7 months, versus 7.1 months in nonspecific treatment). Thus, it is unclear whether a non-offense-specific treatment program comparable to a sex offender treatment program in terms of intensity and breadth of services would yield outcome results comparable to those of the Kimball and Guarino-Ghezzi study, especially for offenders who do not evidence patterns of deviant arousal.

In another study, Becker (as cited in Weinrott, 1996) described the effectiveness of cognitive-behavioral treatment used with a sample of juveniles who abused children younger than themselves. In addition to psychoeducational and cognitive approaches, this treatment used interpersonal skills training and behavioral interventions to reduce deviant arousal. Results indicated a 10-percent recidivism rate for sex offending. This finding, however, was based only on juveniles who completed the program. Furthermore, the followup period was relatively short (1 year), and no control group was used.

Weinrott (1998a) noted that in spite of the limited treatment research, empirically based approaches should be emphasized in the treatment of juvenile sex offenders. For example, he encouraged practitioners to provide juvenile sex offenders who engage in various types of delinquent behaviors with empirically based treatment approaches that have been designed specifically for delinquent populations.

Treatment for Juveniles Who Are Delinquent

The following studies describe research that has assessed the effectiveness of interventions with juveniles who commit various types of offenses, not just sex offenses. As previously noted, because general delinquency and antisocial attitudes and behavior are frequently found in juveniles who have

committed sex offenses, these treatment approaches may be relevant and effective with these juveniles.

Izzo and Ross (1990) conducted a meta-analysis of rehabilitation programs designed for all juvenile delinquents, not just those who have committed sex offenses. Their findings suggested that programs based on cognitive therapy were twice as effective as those using other approaches. They defined cognitive therapy as approaches that employed one or more of six intervention modalities: problem solving, negotiation skills training, interpersonal skills training, rational-emotive therapy, role playing and modeling, and cognitive behavior modification.

More recently, Lipsey and Wilson (1998) conducted a meta-analysis of 200 experimental or quasi-experimental studies to assess the effectiveness of treatment interventions used with juvenile offenders. Because of variability between treatment approaches and sample characteristics, the findings from this meta-analysis require further study and should in the meantime be considered to be suggestive only. The findings are, however, consistent with reviews of the literature (Tolan and Guerra, 1994) and previous meta-analytic results (Lipsey, as cited in Lipsey and Wilson, 1998).

In sum, Lipsey and Wilson (1998) found that among noninstitutionalized juveniles, treatments that focused on interpersonal skills (e.g., social skills training, anger management, and moral education) and used behavioral programs consistently yielded positive effects. Contrary to findings from previous studies (Lipsey, as cited in Lipsey and Wilson, 1998; Tolan and Guerra, 1994), individual counseling also showed consistent positive effects. This surprising finding may be a result of the types of interventions that this study considered as "individual counseling." One approach involved a 12-week reality therapy program that emphasized client accountability and responsibility, behavior assessments, and action plans.

The other treatment that was included in the "individual counseling" category was multisystemic therapy (MST) (Lipsey and Wilson, 1998). MST is an empirically based intervention that has been validated with chronic juvenile delinquents and substance-abusing juveniles (Henggeler et al., 1998). It is also the only approach that has been empirically validated as effective with juvenile sex offenders (Borduin et al., 1990), although the sample size in the validation study was small and the comparison treatment did not involve current treatment approaches. MST confronts antisocial behavior in juveniles by targeting their "social-ecological context" (i.e., their family, neighborhood, school, and community) (Henggeler et al., 1998). Thus, although interventions may (or may not) involve individual interventions with the juveniles, this approach certainly cannot be considered individual counseling in the usual sense. MST individual interventions, for example, may involve parent figures, with or without the juvenile present. The importance of MST for juvenile sex offenders has increasingly been noted (Bourke and Donohue, 1996; Cellini, 1995; Swenson et al., 1998).

Results of the meta-analysis (Lipsey and Wilson, 1998) further indicated that other interventions with noninstitutionalized juvenile offenders have shown positive but less consistent evidence of effectiveness. These interventions include programs that provide multiple services (e.g., vocational training, skills-oriented education, job placement, community supervision) and those that require restitution or supervision through probation and parole. Mixed but generally positive effects were found in some studies for the following interventions: employment-related services, academic programming, advocacy and casework approaches, and family and group counseling. In contrast, weak or no effects were consistently found for early release, deterrence, vocational, and wilderness/challenge programs.

Findings regarding institutionalized juvenile offenders indicated consistent, positive effects for programs that focused on interpersonal skills (Lipsey and Wilson, 1998). One treatment approach, the teaching-family home model mentioned previously (Lee and Olender, 1992; Lipsey and Wilson, 1998), involves juveniles who frequently are referred from detention facilities or placements more restrictive than foster care. The teaching-family home model uses "teaching parents" to help juveniles develop necessary life skills and enhance social competence.

Positive but less consistent results were found for behavioral programs, community residential approaches, and programs that provided multiple

services. Inconsistent evidence of mixed but generally positive effects was found for individual counseling, guided group interventions, and group counseling. In contrast, weak or no effects were consistently found for milieu therapy approaches.

Lipsey and Wilson (1998) noted that the impact of the most effective treatments on recidivism was substantial:

> The most effective treatment types had an impact on recidivism that was equivalent to reducing a .50 control group baseline to around .30. In other words, we estimated that without treatment the recidivism would have been 50%. If they received the most effective of the treatments reviewed in this meta-analysis, their recidivism would have dropped to about 30%. (p. 333)

Chamberlain and Reid (1998) contrasted traditional community group placements with multidimensional treatment foster care (MTFC) to investigate an alternative to MST for juveniles whose parents were unable, for various reasons, to provide the "corrective or therapeutic parenting" the juveniles needed. Like MST, MTFC involves multiple treatment modes and targets, including individual therapy, family therapy, and interventions at home, at school, and among peer groups. In the Chamberlain and Reid study, chronic juvenile delinquents, including some juvenile sex offenders, were randomly assigned to either MTFC or traditional community-based group care settings. Results indicated that juveniles in MTFC had significantly fewer justice system referrals and returned home to relatives more often than those in community-based group care settings. Multiple regression analysis showed that assignment to the MTFC treatment condition was a better predictor of reduced offense rates (official and self-reported) than other well-known predictors.

Attrition From Sex-Offense-Specific Treatment

Studies of treatment programs for juveniles who have sexually offended have demonstrated high rates of treatment dropouts. For example, Becker (1990) found that only 27.3 percent of her sample attended 70 to 100 percent of scheduled therapy sessions and only 45.4 percent completed at least half of the sessions. Kraemer, Salisbury, and Spielman (1998) reported that completion rates for residential juvenile sex offender programs in Minnesota appeared to range from 30 to 50 percent. Their study suggested that older age and impulsivity were associated with treatment dropout. Rasmussen (1999) found that only half of the subjects in her sample completed the initial stage of their treatment and one-third failed to complete the full course of treatment once they began. (The remaining subjects either were not referred for treatment or did not follow through on the referral.) Schram, Milloy, and Rowe (1991) found that most offenders terminated treatment as soon as their sentence or court order ended. Only 39 percent of their sample completed treatment.

Similarly, Hunter and Figueredo (1999) reported that more than 50 percent of the subjects in their sample terminated or were terminated from treatment during the first year. Although 20 percent of these juveniles ended treatment for reasons unrelated to their behavior or attitudes (e.g., family relocation), 33 percent were expelled from the program as treatment failures. Of the "treatment failures," more than 75 percent were terminated because they were noncompliant with attendance and therapeutic directives. Only 11.4 percent of the "treatment failures" were terminated because of recidivism (4.9 percent for sex offenses, 6.6 percent for other types of offenses).

In another study, O'Brien (as cited in Weinrott, 1996) found that only 6 percent of 200 juvenile sex offenders who completed a treatment program committed another sex offense after being referred to the program. Although the study did not provide information about the number of juveniles who dropped out of treatment prematurely, the researchers did note that half of the juveniles who reoffended did so before they completed the treatment program.

High rates of treatment attrition are extremely important. Studies with juvenile sex offenders (Hunter and Figueredo, 1999) and adult sex offenders (Becker and Hunter, as cited in Rasmussen, 1999; Hanson and Buissière, 1998; Marques, Day, Nelson, and

West, as cited in Hunter and Figueredo, 1999; Marshall et al., as cited in Rasmussen, 1999) suggest that failing to complete treatment is associated with higher rates of recidivism for both sex offenses and other types of offenses.

Treatment Setting

Segregating Versus Integrating Juveniles Who Have Committed Sex Offenses

Historically, treating juveniles who have committed sex offenses in a setting specifically designed for sex offenders has been considered "optimal" (Morenz and Becker, 1995). The literature, however, indicates that the effectiveness of this approach has not been proven. In fact, as some of the studies reviewed above suggest, other approaches (e.g., MST and MTFC) may be more beneficial. Noting the absence of significant differences between groups of juvenile sex offenders and other juvenile offenders in the research that they and others have conducted, Jacobs, Kennedy, and Meyer (1997) concluded, "The similarities are indicative of commensurate therapeutic needs for both types of offenders" (p. 201).

Milloy (1994) asked the question, "But what is specialized sex offender treatment?" She pointed out that "specialized" treatment for sex offenders typically includes components such as sex education, social skills, anger management, acceptance of responsibility for one's offenses, and empathy for victims. Yet these components may be appropriate for juvenile offenders in general.

As Milloy (1994) pointed out, one of the arguments in favor of specialized and segregated sex offender treatment programs is that these offenders frequently intimidate staff and other residents through their manipulative or aggressive behaviors. The results of Milloy's study, however, suggested that juveniles who committed sex offenses were not more likely to be exploitative, manipulative, or aggressive than juveniles who committed other types of offenses. The frequency of verbal and physical threats did not differ between the groups, and the sex offenders did not present increased management risks or security risks within the institution.

In conclusion, Milloy (1994) indicated that no controlled studies have been published investigating the effect of segregating juvenile sex offenders from the general delinquent population. She stated, "This fact, coupled with the findings from this study, suggest that the segregation of juvenile sex offenders is a costly approach whose worth is unproven" (p. 10).

Whether juveniles who have been sexually abusive should be grouped with juveniles who have committed nonsexual offenses or with juveniles who have other behavioral problems is a complex issue. Clearly, other factors must be considered when designing appropriate treatments and treatment settings. Among these factors is the safety of all juveniles involved, since the juveniles who have committed sex offenses might become targets themselves or might target others.

Another factor cited as supportive of segregated treatment units is the reduction of staff training needs that results when intensive training in sex-offending issues is provided only to those whose jobs involve this specialized treatment (Bengis, 1997). Other arguments in favor of segregated units include the possibility that such units may form stronger and more effective treatment cultures (Bengis). On the other hand, research has suggested that delinquent peer group association may increase risk (Ageton, as cited in Prentky et al., 2000). Controlled studies using random assignment to comparison groups are necessary to help resolve the issue of whether juveniles who have committed sex offenses should be segregated from other juveniles in residential care.

In the meantime, the importance of individualized assessment and treatment planning cannot be overemphasized. As Kavoussi, Kaplan, and Becker (1988) point out, the heterogeneity of juvenile sex offenders "suggests that no single treatment regime will be effective in all cases" (p. 243). Furthermore, a one-size-fits-all approach can be costly and may be harmful to the juveniles and their families (Becker, 1998). As Chaffin and Bonner (1998) point out,

> [P]erhaps it is time to emphasize some flexibility and compassion in which treatments we choose and to which individual youngsters we apply them and to realize that individual need, not dogma, should dictate what must be accomplished (p. 316).

Facilitating Safety in Residential Treatment Settings

The issue of community safety exists regardless of whether a juvenile sex offender remains in the community or is placed in a segregated or unsegregated residential facility. NAPN (1993) provided specific recommendations to facilitate safety in residential treatment facilities. These recommendations suggest that such programs should ensure the following:

> 1. A systems based program design for sexual abuse prevention in the institutional setting, which includes (a) policies and procedures reflecting an open and safe system that addresses safety, children's rights, and familial rights; (b) procedures for selecting, screening, training, and supervising staff to decrease the risk of sexually abusive behavior; (c) staff guidelines for interventions with residents; (d) safety education for residents; (e) protocols ensuring environmental safety; (f) procedures addressing allegations or disclosures of sexual abuse; and (g) internal evaluations and external reviews.
>
> 2. A strong, structured behavior management program where management and control of behavior is maintained through program structure and staff/patient interactions.
>
> 3. A safe therapeutic environment and an effective therapeutic milieu.
>
> 4. Close staff supervision based on a high staff-patient ratio and continuous monitoring by staff of all interactions. Video and audio monitors and sensors may also be in use in common areas but do not replace staff presence.
>
> 5. A therapeutic milieu which includes a facility safe environment, secure space, a strong peer culture, and a program philosophy which is consistent throughout.
>
> 6. A structured, well-balanced program which provides modalities developed to impact on adolescent problems and which allows very little unstructured time.
>
> 7. Highly trained staff who have received specialized training in child sexual abuse issues, with emphasis on treatment of youthful victims and sexually abusive youth.
>
> 8. A multidisciplinary, multimodal design to impact on the treatment issues of both victims and sexually abusive youth.
>
> 9. A positive human sexuality program that emphasizes the development of positive attitudes about sexuality, healthy relationships, and safe sexual practices.
>
> 10. Ongoing, planned program evaluations. (pp. 75–76)

Other recommendations from the National Task Force on Juvenile Sexual Offending (as cited in NAPN, 1993) include having clear rules about personal space boundaries and touching. Recommendations also include having night staff who remain awake and monitor residents both randomly and at frequent, planned intervals throughout the night. Ross and Villier (1993) provided more detailed recommendations related to screening program applicants, selecting staff, and designing and supervising living units in a way that maximizes the safety of residents and staff.

Special Populations

Treatment of Young and Preadolescent Children With Sexual Behavior Problems

Gray (as cited in Araji, 1997) proposed that treatment goals that balance community safety and the promotion of developmentally appropriate competencies are most effective in treating children with sexual behavior problems. More specifically, Gray and Pithers (1993) suggested that abusive behaviors might be most effectively addressed by targeting risk factors that predispose a child to sexual behavior problems or that precipitate or perpetuate the problems. Gray and Pithers proposed the following approaches:

> 1. Enhancing self-management skills of sexually aggressive children.
>
> 2. Resolving trauma resulting from the child's own victimization.

3. Addressing compensatory reactions often associated with externalization of difficult emotions through problematic behaviors.

4. Increasing the extent to which prevention team members model abuse-preventive beliefs and intervene when abuse-related behaviors are observed. (p. 308)

Another component of treatment for children with sexual behavior problems is the "prevention team" (e.g., selected family members, care providers, and community advocates) (Gray and Pithers, 1993). The prevention team is of primary importance when intervening with young children who do not have the developmental capacity for self-monitoring.

According to Johnson (1991), interventions with children who are sexually abusive and aggressive should involve reporting the sexual behaviors to appropriate agencies, such as protective services and the police; working with appropriate agencies to ensure the safety of the victim, potential victims, and the abusing child; and working with the courts responsible for juveniles. Johnson observed that interventions should begin with an assessment of the child's treatment needs, to facilitate appropriate placement and treatment.

In her book, Araji (1997) described 10 treatment programs and practices for children with sexual behavior problems, including Johnson's (as cited in Araji). Araji identified these programs by reviewing the professional literature and attending workshops and through personal correspondence. She stated that the programs described simply represent current treatment efforts and trends, noting that the effectiveness of most of the programs has not been demonstrated. The federally funded work of Pithers et al. (1998a, 1998b), as described below, and the ongoing work of Bonner, Walker, and Berliner (as described in Araji, 1997) are important exceptions.

Most of the programs reviewed by Araji use theories from the sex abuse literature. Some appear to emphasize personal histories of sexual abuse as a factor contributing to sexual behavior problems in children, although the literature suggests that this issue may be overemphasized in the context of multiple risk factors.

The programs reviewed by Araji also used child development literature and designed interventions that were appropriate to different ages and cognitive and developmental levels. Programs typically targeted prevention of perpetration. Techniques frequently involved modifications of approaches used with adults or adolescents who commit sex offenses, such as the relapse prevention and assault cycle approaches discussed previously.

All of the programs reviewed used a cognitive-behavioral approach, although some also used other orientations, such as those based on psychodynamic and attachment theories. Cognitive-behavioral interventions included skill development to promote prosocial coping and problem solving, age-appropriate interpersonal relationships and sexual behaviors, and abuse prevention strategies. In her review, Araji noted that because no treatment approach has been demonstrated to be superior to others, treatment that combines theories and methods might better meet the needs of these children and their families.

Treatment modalities in the programs reviewed by Araji include individual, group, pair, and family therapy. Most providers appeared to prefer group therapies. Araji's views appear consistent with those of Johnson (1991), who stated: "The group format allows the therapists to use the group members to help each other understand and work on the 'touching' problems. The aim is to help the children interact without being sexually or behaviorally inappropriate" (p. 11). Araji also noted that groups can help reduce children's social isolation and are efficient in terms of cost and time. Others (Friedrich and Gil, as cited in Araji, 1997) consider pair therapy (two children treated together) more beneficial. Advocates of the pair therapy approach believe that it may minimize anxieties, avoid rejections, and enhance controlled peer interactions.

Developmental issues. Other factors considered of great importance when intervening with children who have been sexually abusive are developmental issues. As Friedrich (as cited in Araji, 1997) noted, substantial differences may exist between a 6-year-old child who has been sexually aggressive and a 10-year-old child who has been sexually aggressive. Even if the acts appear similar, differences may

include the meaning the child attributes to the act, differences in peer relationships, and other factors (including, for a child who has been the victim of sexual abuse, the length of time between the victimization and the child's abusive behavior).

Friedrich (as cited in Araji, 1997) also argued that sexual aggression in children reflects difficulties with a child's ability to modulate emotions and behavior. Sexual aggression is considered to be similar to other behavioral and psychological problems or disorders, such as fire setting, stealing, and posttraumatic stress disorders. Interventions found effective with these other forms of behavioral and emotional dysregulation—such as increasing parental supervision and positive interactions with parents—can be valuable for children who have been sexually abusive and may be sufficient for eliminating such behaviors in some children. Friedrich also argued that when children have suffered traumas, the underlying issues that may have resulted require intervention if positive, lasting changes are to be achieved.

Family involvement. Although the programs reviewed by Araji (1997) varied in terms of the range of interventions they provided to parents or other caregivers, all of them involved parents or other caregivers, either in group interventions or through other approaches. Treatment goals with caregivers typically included improving parental supervision and parenting skills and increasing parental knowledge about sex abuse; in some programs, treatment goals also included providing specific training to help parents help their children succeed at relapse prevention. In view of the high levels of stress, personal and interpersonal difficulties, and impaired parent-child attachments found in their study (as described previously, in the section on "Young Children Who Have Committed Sex Offenses: Family Characteristics"), Pithers et al. (1998a) noted the need for group treatment for parents of children with sexual behavior problems. Pithers et al. suggested that such groups address issues of parental attachment, parental training, social-relational skills, trauma resolution, and, when indicated, the opportunity to grieve the loss of an idealized child and family.

Specialized therapeutic foster homes have been developed in some areas to provide interventions for children who are sexually abusive and require out-of-home placement but not residential care. One small study (Ray et al., 1995) involved 15 children who came from chaotic, violent, and abusive homes and were placed in therapeutic foster homes. These youngsters typically were under 13 years old, but occasionally older children with cognitive difficulties were accepted into the program. Researchers found that the children evidenced improvements in behavior, emotional adjustment, social functioning, family relationships, and overall adjustment. Improvements in life skills were not statistically significant but appeared to be moving in the expected direction. Although four of the children displayed inappropriate sexual behavior early in treatment, none of the children continued to do so at the completion of treatment. Followup interviews indicated that the children continued to have serious emotional and behavioral problems, but with the exception of two of the children, their sexually abusive behavior appeared to have subsided. This study is limited by its small sample size, lack of a comparison group, and other problems. In spite of these limitations, however, the advantages of foster care approaches in helping to stabilize a child and provide appropriate interventions warrant further study.

As Araji (1997) noted in her book, "Sexually abusing behavior by children is a complex phenomenon presented by multiproblem youth and, frequently, multiproblem families. . . . The programs, agencies, and practices reviewed all recognize the importance of developing individualized treatment plans" (p. 184). In addition, Araji noted that although a variety of interventions may be required, ranging from community-based approaches to residential care, "helping families to create safe, predictable, and growth promoting relationships among family members is key to helping the sexually reactive and sexually aggressive child" (p. 187).

A comparative study. As noted previously (in the section on "Young Children Who Have Committed Sex Offenses: Types and Classifications"), Pithers et al. (1998b) identified five subtypes of children with sexual behavior problems: sexually aggressive, nonsymptomatic, highly traumatized, abusive reactive, and rule breaker. Their investigations also revealed some differences in how children in various subtype classifications responded to different types of treatment.

At intake, the children and their families were randomly assigned to one of two 32-week treatment conditions. One treatment involved expressive therapy, reportedly recommended by some national experts as the treatment of choice for children with behavioral problems. The other treatment was a substantially modified form of relapse prevention. Both approaches involved parents in parallel group interventions. The Child Sexual Behavior Inventory-3 (CSBI–3) was used to measure progress.

Results indicated that children in most of the subtypes evidenced similar degrees of change regardless of treatment modality. The highly traumatized children, however, benefited significantly more from modified relapse prevention than from expressive therapy. In fact, highly traumatized children who were in expressive therapy actually evidenced a slight increase in sexualized behavior. The number of children classified as sexually aggressive evidencing a reduction in sexual behavior problems was slightly larger in expressive therapy than in modified relapse prevention therapy, but this finding was tempered by the fact that a similar number of children in expressive therapy who were classified as sexually aggressive had an increase in sexual behavior problems.

Results further indicated that children in some subtypes responded well to treatment, whereas those in other subtypes did not. For example, more than half of the highly traumatized children evidenced significant reductions in problematic sexual behavior after the first 16 weeks of treatment. In contrast, only 7 percent of the sexually aggressive children demonstrated significant decreases in their sexual behavior problems.

Treatment of Juveniles With Cognitive or Developmental Disabilities

Special interventions may be necessary for juveniles with intellectual and cognitive impairments. Furthermore, these juveniles may be difficult to engage in standard treatment approaches. Langevin, Marentette, and Rosati (1996) proposed that learning difficulties may affect therapy in at least two ways. First, during therapy sessions, a person with learning difficulties may not be able to process the same information that a person of average intellectual abilities could. Second, individuals with learning difficulties may have developed negative attitudes toward learning situations and, "in particular, avoid classroom type experiences where they may have met failure and derision from other students" (p. 145). As a result, these individuals may prefer to avoid therapeutic situations that resemble their negative experiences, such as psychoeducational programs and other cognitive-behavioral approaches.

Langevin, Marentette, and Rosati (1996) found some support for these theories in their study of adult sex offenders. Although they did not find that the subjects' attitudes toward therapy were significantly related to education or level of intelligence, they did find a negative correlation between attitude and Halstead Reitan Impairment Index scores. In other words, individuals who evidenced significant neuropsychological impairment on the Halstead Reitan Index evidenced more negative attitudes toward therapy.

A review of the literature (Stermac and Sheridan, 1993) regarding treatment of "developmentally disabled" adults and adolescents revealed a "dearth of work in this area" (p. 237). Most studies have focused on adult offenders and have stressed behaviorally oriented interventions. Pharmacological approaches also have been used with developmentally disabled sex offenders. As noted previously (in the section on "Treatment Approaches: Overview"), sex-drive reducing medications such as medroxyprogesterone can be effective in reducing sex offending, but because of potentially serious side effects and ethical concerns, the use of these medications for juveniles requires appropriate informed consent from guardians; additionally, the appropriateness of these medications for juveniles who have committed sex offenses has been questioned (Hunter and Lexier, 1998).

Most interventions involving adolescents with developmental disabilities who have committed sex offenses have used approaches modified from adult sex offender treatment programs (Stermac and Sheridan, 1993). Strategies to enhance learning and generalizing skills and coping strategies are recommended. Modified relapse prevention strategies have been found to be effective with some cognitively impaired sex offenders. Yet, as Stermac and Sheridan

(1993) pointed out, relapse prevention emphasizes self-management and therefore may not be appropriate for all intellectually or cognitively impaired sex offenders.

Langevin, Marentette, and Rosati (1996) urged treatment professionals to reach out to these juveniles. They suggested the following steps:

- Address the juvenile's learning difficulties and attitudes at the outset.
- Use an individualized treatment and problem-solving approach that helps the juvenile resolve practical problems first before focusing on sex-offending issues.
- Reward strengths rather than focusing on weaknesses.

Research concerning intellectual, cognitive, and neurological impairments in juvenile sex offenders (previously discussed in the section on "Characteristics: Academic and Cognitive Functioning") also points to the necessity of developing individualized interventions that are tailored to the special needs of these juveniles. Although a more indepth discussion of specialized interventions with juveniles who have intellectual, cognitive, and neurological problems is beyond the scope of this Report, Ferrara and McDonald (1996) provide a detailed discussion of treatment strategies and techniques that may be useful. These authors draw on work from other related fields, such as the treatment of persons with brain injuries, and apply this knowledge to interventions designed for juveniles who are sexually aggressive. For example, Ferrara and McDonald describe techniques designed specifically to facilitate learning, promote attention and concentration, and improve recall. Treatment approaches described are multimodal, applied in multiple settings, and tailored to the juvenile's individual needs.

Training and Qualifications of Treatment Providers

Individuals providing treatment for juveniles with sexual behavior problems must be personally and professionally qualified (Association for the Treatment of Sexual Abusers, 1997a; NAPN, 1993). Personal qualifications include being emotionally healthy, having respect for oneself and others, using good listening skills, and having the ability to empathize. Professional qualifications include relevant education, training, and experience. Treatment providers should receive training before they begin their interventions. Training should then take place on a continuing basis, so providers can stay current with this evolving field.

More specifically, Goocher (1994) stressed the importance of "adequate training in normal adolescent development, the etiology and behavior manifestations of psychiatric disorders, and how to reinforce initial efforts of young people to learn new patterns of behavior and to come to terms with their own personal histories" (p. 249). Goocher also recommended additional training in how to help juveniles develop adequate verbal and personal skills and problem-solving abilities.

To be effective, Friedrich (as cited in Araji, 1997) suggested that therapists who work with sexually aggressive children should receive good training in issues pertaining to victimization and the development of violence and aggression. Araji (1997) noted that therapists also must be well aware of normative childhood sexual behaviors. Furthermore, the importance of developmental issues regarding attachment and the capacity for moral reasoning, empathy, and autonomy cannot be ignored (Pithers, Kashima, Cummings, Beal, and Buell, as cited in Araji, 1997). These suggestions clearly are important for those who treat adolescents and those who treat younger children.

Working with juveniles who have sexual behavior problems is a challenging job. In addition to concerns about protecting community safety, providing sound treatment, and dealing with significant human suffering, individuals who work with these juveniles are exposed to a great deal of distorted thinking and deviant sexual behavior. As NAPN (1993) observed, "Systems must be aware of potential emotional/psychological impacts on providers and take steps to protect against or counter negative effects" (p. 46).

Program Evaluation

Adequate program evaluation involves at least two primary approaches. First, implementation research is conducted to ensure that the components necessary for effective treatment exist and are implemented. Second, outcome research is necessary to determine whether the interventions have been effective. In spite of the important functions that program evaluation serves, evaluations of sex offender treatment programs have been few, and those that have been conducted often have had inadequate designs (Camp and Thyer, 1993). The literature provides some examples and ideas for future endeavors.

Most outcome studies have used recidivism rates to assess treatment effectiveness. Yet generally low rates of recidivism, short followup periods, variability in outcome measures (e.g., arrest or adjudication), and other methodological problems limit the usefulness of this approach. Other approaches to assessing treatment effectiveness are required.

Two studies have used self-report measures to evaluate the effectiveness of treatment programs. Hains, Herman, Baker, and Graber (as cited in Camp and Thyer, 1993) conducted pretreatment and posttreatment tests with adolescents in a residential sex offender program and with those on a waiting list. The researchers found significant improvements in social competency following treatment. In addition to examining recidivism data and parole violations, Miner, Siekert, and Ackland (1997) conducted pretreatment and posttreatment assessments with psychological measures such as the Jesness Behavioral Checklist and the Multiphasic Sex Inventory-Juvenile Revised (MSI–JR). As Kraemer, Spielman, and Salisbury (1995) noted, such self-report and objective measures provide a norm-based reference group that can be useful in assessing treatment progress.

Laben, Dodd, and Sneed (1991) used goal attainment theory to develop measurable outcomes in an inpatient juvenile sex offender treatment program. This approach required treatment providers and clients to establish mutual goals through a process of bargaining, negotiating, identifying commonalties, and defining measurable outcomes. Because initial group assessment indicated that treatment group members were very concrete in their thinking and had significant difficulties with verbal reasoning, researchers used visual aids to facilitate the goal attainment and treatment process. When a juvenile successfully completed each identified goal, a staff member would check it off on a written list. When all the goals were met, the juvenile's inpatient treatment was completed.

Goal attainment scaling (GAS) also was used in a study of hospitalized adult sex offenders (Lang, Lloyd, and Fiqia, 1985). In this study, patients and therapists developed individualized scaled descriptions of goals, which were measured to assess treatment outcome. Goals and treatment outcomes were measured on a scale ranging from –2 (least favorable outcome) to +2 (most favorable outcome), with 0 representing the expected treatment outcome. At followup, 38 patients had exceeded the "expected" success level, whereas 8 patients were found to have made minimal progress. The authors collapsed 176 of the 180 treatment goals into 4 primary content areas: sexual deviation (30 goals), anger and emotional expression (64 goals), self-concept (31 goals), and poor interpersonal relations (51 goals). The authors concluded: "As an adjunct to therapy, GAS can provide data on desired change over time on each patient's interpersonal, social, and psychosexual adjustment" (p. 536). They also noted that program quality assurance may be enhanced through retrospective reviews of goal attainment profiles and program improvements that result from the reviews.

The importance of program evaluation cannot be overemphasized. Also, as this literature review suggests, effective and humane interventions for juveniles with sexual behavior problems should be individualized, be empirically based whenever possible, facilitate family involvement, and, when program participation is indicated, promote program completion. As Rasmussen (1999) suggested, "Administrators in the juvenile justice system would do well to provide support for those treatment programs that involve families, have specific goals and objectives, and carefully monitor successful completion of treatment" (p. 82).

Conclusions

The findings of this literature review indicate that juveniles who have committed sex offenses are a heterogeneous group who, like all juveniles, have developmental needs, but who also have special needs and present special risks related to their abusive behaviors. There currently are no empirically validated and accepted classification schemes for differentiating types of juveniles who have sexually offended. However, the relatively low known rates of recidivism and existing studies suggesting that a substantial proportion of these juveniles desist from committing sex offenses following the initial disclosed offense and intervention appear to support theoretical classifications. It may be that relatively smaller groups commit additional offenses, including sex offenses, other offenses, or both.

The literature on assessment and treatment clearly supports the importance of interventions that are tailored to the individual juvenile. Risk management strategies likely to be most effective are those that address the needs underlying a juvenile's behavior and make the most of the juvenile's existing strengths and positive supports. Treatment effectiveness is likely to be enhanced by interventions that motivate the juvenile to make positive changes and that facilitate efforts to do so by being responsive to learning or personality styles or other individual characteristics.

Interventions should target factors that are empirically associated with the risk of sex offending specifically (e.g., deviant arousal and limited social competence) and factors associated with delinquent offending in general (e.g., delinquent peers and antisocial attitudes). In addition, appropriate targets of intervention include those that appear theoretically relevant but that either have not yet been studied or have not been demonstrated to be consistently related to risk (e.g., inadequate dating skills).

When selecting appropriate treatment programs and interventions, Chaffin and Bonner's (1998) cautionary remarks should be remembered. They observed that efficacy has not been established for many sex offender interventions considered standard and required. On the other hand, as this literature review has described, there is a wide range of interventions with more of an empirical basis, particularly within the juvenile justice field (such as MST), that may be effective. It also should be remembered that some juveniles may require minimal interventions once their sex offending has been disclosed. An additional —and important—caution is that treatment efforts certainly should not be harmful.

Lastly, it should be remembered that the goal when working with juveniles who have committed sex offenses is to help them stop their abusive behaviors. To label them "juvenile sex offenders" at a time when they are developing their identity may have deleterious effects. There is no evidence pertaining to these juveniles that suggests once a sex offender, always a sex offender, as Chaffin and Bonner (1998) point out in their editorial "Don't Shoot, We're Your Children: Have We Gone Too Far in Our Response to Adolescent Sexual Abusers and Children With Sexual Behavior Problems?" Instead, it is important to remember that they are children and adolescents first—they are young people who have committed offenses and who deserve care and attention.

References

Abel, G.G., Mittelman, M.S., and Becker, J.V. 1985. Sex offenders: Results of assessment and recommendations for treatment in clinical criminology. In *The Assessment and Treatment of Criminal Behavior,* edited by M.H. Ben-Aron, S.J. Hucker, and C.D. Webster. Toronto, Canada: M and M Graphic, pp. 191–205.

Abel, G.G., Osborn, C.A., and Twigg, D.A. 1993. Sexual assault through the life span: Adult offenders with juvenile histories. In *The Juvenile Sex Offender,* edited by H.E. Barbaree, W.L. Marshall, and S.M. Hudson. New York, NY: Guilford Press, pp. 104–117.

Abel Screening, Inc. 1996. *Abel Assessment for Sexual Interest: Juvenile Sex Offenders: Therapist Product Information.* Brochure. Atlanta, GA: Abel Screening, Inc.

Araji, S. 1997. *Sexually Aggressive Children: Coming To Understand Them.* Thousand Oaks, CA: Sage Publications.

Association for the Treatment of Sexual Abusers. 1997a. *Ethical Standards and Principles for the Management of Sexual Abusers.* Beaverton, OR: Association for the Treatment of Sexual Abusers.

Association for the Treatment of Sexual Abusers. 1997b. *Position on the Effective Legal Management of Juvenile Sexual Offenders.* Beaverton, OR: Association for the Treatment of Sexual Abusers.

Avalon Associates. 1986. *The Oregon Report on Juvenile Sex Offenders*. Salem, OR: Children's Services Division, Department of Human Resources.

Awad, G.A., and Saunders, E. 1991. Male adolescent sexual assaulters, clinical observations. *Journal of Interpersonal Violence* 6(4):446–460.

Bagley, C., and Shewchuk-Dann, D. 1991. Characteristics of 60 children and adolescents who have a history of sexual assault against others: Evidence from a controlled study. *Journal of Child and Youth Care* (Fall Special Issue):43–52.

Barbaree, H.E., and Cortoni, F.A. 1993. Treatment of the juvenile sex offender within the criminal justice and mental health systems. In *The Juvenile Sex Offender,* edited by H.E. Barbaree, W.L. Marshall, and S.M. Hudson. New York, NY: Guilford Press, pp. 243–263.

Becker, J.V. 1990. Treating adolescent sexual offenders. *Professional Psychology: Research and Practice* 21(5):362–365.

Becker, J.V. 1998. What we know about the characteristics and treatment of adolescents who have committed sexual offenses. *Child Maltreatment* 3(4):317–329.

Becker, J.V., and Hunter, J.A. 1997. Understanding and treating child and adolescent sexual offenders. In *Advances in Clinical Child Psychology*, vol. 19, edited by T.H. Ollendick and R.J. Prinz. New York, NY: Plenum Press, pp. 177–197.

Becker, J.V., and Kaplan, M.S. 1993. Cognitive behavioral treatment of the juvenile sex offender. In *The Juvenile Sex Offender,* edited by H.E. Barbaree, W.L. Marshall, and S.M. Hudson. New York, NY: Guilford Press, pp. 264–277.

Becker, J.V., Kaplan, M.S., Cunningham-Rathner, J., and Kavoussi, R. 1986. Characteristics of adolescent incest sexual perpetrators: Preliminary findings. *Journal of Family Violence* 1(1):85–97.

Bengis, S. 1997. Comprehensive service delivery with a continuum of care. In *Juvenile Sexual Offending: Causes, Consequences, and Correction,* edited by G.D. Ryan and S.L. Lane. San Francisco, CA: Jossey-Bass Publishers, pp. 211–218.

Bonner, B. 1997. Child, adolescent, and adult sex offenders: Similarities and differences. Paper presented at the meeting of the Association for the Treatment of Sexual Abusers, Arlington, VA, October 1997.

Bonner, B., and Chaffin, M. 1998. Dyad and family therapy in sibling abuse and sibling sexual behavior. Workshop presented at the Conference on Responding to Child Maltreatment, American Professional Society on the Abuse of Children (APSAC) Advanced Training Institute, San Diego, CA, January 1998.

Bonner, B., Marx, B.P., Thompson, J.M., and Michaelson, P. 1998. Assessment of adolescent sexual offenders. *Child Maltreatment* 3(4):374–383.

Borduin, C.M., Henggeler, S.W., Blaske, D.M., and Stein, R.J. 1990. Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology* 34(2):105–113.

Bourke, M.L., and Donohue, B. 1996. Assessment and treatment of juvenile sex offenders: An empirical review. *Journal of Child Sexual Abuse* 5(1):47–70.

Bremer, J.F. 1992. Serious juvenile sex offenders: Treatment and long-term follow-up. *Psychiatric Annals* 22(6):326–332.

Bumby, K.M., and Bumby, N.H. 1997. Adolescent female sexual offenders. In *The Sex Offender: Vol. 2. New Insights, Treatment Innovations and Legal Developments,* edited by B.K. Schwartz and H.R. Cellini. Kingston, NJ: Civic Research Institute, pp. 10.1–10.16.

Camp, B.H., and Thyer, B.A. 1993. Treatment of adolescent sex offenders: A review of empirical research. *The Journal of Applied Social Sciences* 17(2):191–206.

Carpenter, D.R., Peed, S.F., and Eastman, B. 1995. Personality characteristics of adolescent sexual offenders: A pilot study. *Sexual Abuse: A Journal of Research and Treatment* 7(3):195–203.

Cellini, H.R. 1995. Assessment and treatment of the adolescent sexual offender. In *The Sex Offender: Vol. 1. Corrections, Treatment and Legal Practice*, edited by B.K. Schwartz and H.R. Cellini. Kingston, NJ: Civic Research Institute, pp. 6.1–6.12.

Chaffin, M. 1994. Research in action: Assessment and treatment of child sexual abusers. *Journal of Interpersonal Violence* 9:224–237.

Chaffin, M., and Bonner, B. 1998. Don't shoot, we're your children: Have we gone too far in our response to adolescent sexual abusers and children with sexual behavior problems? *Child Maltreatment* 3(4):314–316.

Chamberlain, P., and Reid, J.B. 1998. Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology* 66(4):624–633.

Charles, G., and McDonald, M. 1997. Adolescent sexual offenders. *Journal of Child and Youth Care* 11(1):15–25.

Davis, G.E., and Leitenberg, H. 1987. Adolescent sex offenders. *Psychological Bulletin* 101(3):417–427.

Dougher, M.J. 1995. Clinical assessment of sex offenders. In *The Sex Offender: Vol. 1. Corrections, Treatment and Legal Practice,* edited by B.K. Schwartz and H.R. Cellini. Kingston, NJ: Civic Research Institute, pp. 11.2–11.13.

Epps, K.J. 1994. Managing sexually abusive adolescents in residential settings: A strategy for risk assessment. *Issues in Criminological and Legal Psychology* 21:54–60.

Fehrenbach, P.A., Smith, W., Monastersky, C., and Deisher, R.W. 1986. Adolescent sexual offenders: Offender and offense characteristics. *American Journal of Orthopsychiatry* 56(2):225–233.

Ferrara, M.L., and McDonald, S. 1996. *Treatment of the Juvenile Sex Offender: Neurological and Psychiatric Impairments.* Northvale, NJ: Jason Aronson.

Forth, A.E., and Burke, H.C. 1998. Psychopathy in adolescence: Assessment, violence, and developmental precursors. In *Psychopathy: Theory, Research, and Implications for Society,* edited by D. Cooke, A.E. Forth, and R.D. Hare. Dordrecht, The Netherlands: Kluwer, pp. 205–229.

Forth, A.E., Hart, S.D., and Hare, R.D. 1990. Assessment of psychopathy in male young offenders. *Psychological Assessment: A Journal of Consulting and Clinical Psychology* 2(3):342–344.

Forth, A.E., Kosson, D., and Hare, R.D. In press. *The Psychopathy Checklist: Youth Version.* Toronto, Canada: Multi-Health Systems.

Freeman-Longo, R.E., Bird, S., Stevenson, W.F., and Fiske, J.A. 1994. *1994 Nationwide Survey of Treatment Programs and Models Serving Abuse-Reactive Children and Adolescent and Adult Sex Offenders.* Brandon, VT: The Safer Society Program and Press.

Friedrich, W.N. 1990. *Psychotherapy of Sexually Abused Children and Their Families.* New York, NY: W.W. Norton and Co.

Gilby, R., Wolf, L., and Goldberg, B. 1989. Mentally retarded adolescent sex offenders: A survey and pilot study. *Canadian Journal of Psychiatry* 34(6):542–548.

Goocher, B.E. 1994. Some comments on the residential treatment of juvenile sex offenders. *Child and Youth Care Forum* 23(4):243–250.

Gray, A., Busconi, A., Houchens, P., and Pithers, W.D. 1997. Children with sexual behavior problems and their caregivers: Demographics, functioning, and clinical patterns. *Sexual Abuse: A Journal of Research and Treatment* 9(4):267–290.

Gray, A.S., and Pithers, W.D. 1993. Relapse prevention with sexually aggressive adolescents and children: Expanding treatment and supervision. In *The Juvenile Sex Offender,* edited by H.E. Barbaree, W.L. Marshall, and S.M. Hudson. New York, NY: Guilford Press, pp. 289–319.

Groth, N.A., Longo, R.E., and McFadin, J.B. 1982. Undetected recidivism among rapists and child molesters. *Crime and Delinquency* 28(3):450–458.

Hanson, R.K., and Buissière, M.T. 1996. *Predictors of Sexual Offender Recidivism: A Meta-analysis*. Ottawa, Canada: Solicitor General, Public Works and Government Services.

Hanson, R.K., and Buissière, M.T. 1998. Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology* 66(2):348–362.

Hare, R.D. 1991. *The Hare Psychopathy Checklist—Revised Manual.* North Tonawanda, NY: Multi-Health Systems.

Hare, R.D. 1996. Psychopathy: A clinical construct whose time has come. *Criminal Justice and Behavior* 23(1):25–54.

Harris, G.T., Rice, M.E., and Quinsey, V.L. 1993. Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior* 20(4):315–335.

Henggeler, S.W., Melton, G.B., and Smith, L.A. 1992. Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology* 60(6):953–961.

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., and Cunningham, P.E. 1998. *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents.* New York, NY: Guilford Press.

Hunter, J.A., Jr., and Becker, J.V. 1994. The role of deviant sexual arousal in juvenile sexual offending: Etiology, evaluation, and treatment. *Criminal Justice and Behavior* 21(1):132–149.

Hunter, J.A., Jr., and Figueredo, A.J. 1999. Factors associated with treatment compliance in a population of juvenile sexual offenders. *Sexual Abuse: A Journal of Research and Treatment* 11(1):49–67.

Hunter, J.A., Jr., and Lexier, L.J. 1998. Ethical and legal issues in the assessment and treatment of juvenile sex offenders. *Child Maltreatment* 3(4):339–348.

Izzo, R.H., and Ross, R.R. 1990. Meta-analysis of rehabilitation programs for juvenile delinquents: A brief report. *Criminal Justice and Behavior* 17(1):134–142.

Jacobs, W.L., Kennedy, W.A., and Meyer, J.B. 1997. Juvenile delinquents: A between-group comparison study of sexual and nonsexual offenders. *Sexual Abuse: A Journal of Research and Treatment* 9(3):201–218.

Johnson, T.C. 1991. Children who molest children: Identification and treatment approaches for children who molest other children. *The APSAC Advisor* (Fall):9–11, 23.

Kahn, T.J., and Chambers, H.J. 1991. Assessing reoffense risk with juvenile sexual offenders. *Child Welfare* LXX(3):333–345.

Katz, R.C. 1990. Psychosocial adjustment in adolescent child molesters. *Child Abuse and Neglect* 14(4):567–575.

Kavoussi, R.J., Kaplan, M., and Becker, J.V. 1988. Psychiatric diagnoses in adolescent sex offenders. *Journal of the American Academy of Child and Adolescent Psychiatry* 27(2):241–243.

Kimball, L.M., and Guarino-Ghezzi, S. 1996. *Sex Offender Treatment: An Assessment of Sex Offender Treatment Within the Massachusetts Department of Youth Services.* Juvenile Justice Series Report: No. 10. Boston, MA: Northeastern University, Privatized Research Management Initiative.

Knight, R.A., and Cerce, D.D. 1999. Validation and revision of the Multidimensional Assessment of Sex and Aggression. *Psychologica Belgica* 39(2/3):135–161.

Knight, R.A., and Prentky, R.A. 1993. Exploring characteristics for classifying juvenile sex offenders. In *The Juvenile Sex Offender,* edited by H.E. Barbaree, W.L. Marshall, and S.M. Hudson. New York, NY: Guilford Press, pp. 45–83.

Knight, R.A., Prentky, R.A., and Cerce, D.D. 1994. The development, reliability, and validity of an inventory for the multidimensional assessment of sex and aggression. *Criminal Justice and Behavior* 21(1): 72–94.

Kobayashi, J., Sales, B.D., Becker, J.V., Figueredo, A.J., and Kaplan, M.S. 1995. Perceived parental deviance, parent-child bonding, child abuse, and child sexual aggression. *Sexual Abuse: A Journal of Research and Treatment 7*(1):25–43.

Kraemer, B.D., Salisbury, S.B., and Spielman, C.R. 1998. Pretreatment variables associated with treatment failure in a residential juvenile sex-offender program. *Criminal Justice and Behavior* 25(2):190–202.

Kraemer, B.D., Spielman, C.R., and Salisbury, S.B. 1995. Juvenile sex offending psychometric assessment. In *The Sex Offender: Vol. 1. Corrections, Treatment and Legal Practice,* edited by B.K. Schwartz and H.R. Cellini. Kingston, NJ: Civic Research Institute, pp. 11.1–11.13.

Kramer, S.P., Hurt, R.O., Bench, L.L., Maw, M., and Erickson, S. 1997. A study of twelve measures of recidivism with 200 juvenile sex offenders at 5 year followup. Paper presented at the Association for the Treatment of Sexual Abusers Conference, Arlington, VA, October 1997.

Lab, S., Shields, G., and Schondel, C. 1993. Research note: An evaluation of juvenile sexual offender treatment. *Crime and Delinquency* 39(4):543–553.

Laben, J.K., Dodd, D., and Sneed, L. 1991. King's theory of goal attainment applied in group therapy for inpatient juvenile sexual offenders, maximum security state offenders, and community parolees, using visual aids. *Issues in Mental Health Nursing* 12(1):51–64.

Lane, S., and Lobanov-Rostovsky, C. 1997. Special populations: Children, families, the developmentally disabled, and violent youth. In *Juvenile Sexual Offending: Causes, Consequences, and Correction,* edited by G.D. Ryan and S.L. Lane. San Francisco, CA: Jossey-Bass Publishers, pp. 322–359.

Lang, R.A., Lloyd, C.A., and Fiqia, N.A. 1985. Goal attainment scaling with hospitalized sexual offenders. *The Journal of Nervous and Mental Disease* 173(9):527–537.

Langevin, R., Marentette, D., and Rosati, B. 1996. Why therapy fails with some sex offenders: Learning difficulties examined empirically. In *Sex Offender Treatment: Biological Dysfunction, Intrapsychic Conflict, Interpersonal Violence.* Binghamton, NY: The Haworth Press, pp. 143–155.

Lee, D.G., and Olender, M.B. 1992. Working with juvenile sex offenders in foster care. *Community Alternatives: International Journal of Family Care* 4(2):63–75.

Lightfoot, L.O., and Barbaree, H.E. 1993. The relationship between substance use and abuse and sexual offending in adolescents. In *The Juvenile Sex Offender,* edited by H.E. Barbaree, W.L. Marshall, and S.M. Hudson. New York, NY: Guilford Press, pp. 203–224.

Lipsey, M.W., and Wilson, D.B. 1998. Effective intervention for serious juvenile offenders: A synthesis of research. In *Serious and Violent Juvenile Offenders: Risk Factors and Successful Interventions*, edited by R. Loeber and D.P. Farrington. Thousand Oaks, CA: Sage Publications, pp. 313–345.

MacArthur Violence Risk Assessment Study. 1996. Executive Summary. *American Psychology Law Society News* 16(3):1–4.

Marshall, W.L., and Barbaree, H.E. 1990. Outcome of comprehensive cognitive-behavioral treatment programs. In *Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender,* edited by W.L. Marshall, D.R. Laws, and H.E. Barbaree. New York, NY: Plenum Press, pp. 363–385.

Mathews, R., Hunter, J.A., Jr., and Vuz, J. 1997. Juvenile female sexual offenders: Clinical characteristics and treatment issues. *Sexual Abuse: A Journal of Research and Treatment* 9(3):187–200.

McCurry, C., McClellan, J., Adams, J., Norrei, M., Storck, M., Eisner, A., and Breiger, D. 1998. Sexual behavior associated with low verbal IQ in youth who have severe mental illness. *Mental Retardation* 36(1):23–30.

Milloy, C.D. 1994. *A Comparative Study of Juvenile Sex Offenders and Non-sex Offenders.* Olympia, WA: Washington State Institute for Public Policy.

Milner, J., and Murphy, W. 1995. Assessment of child physical and sexual abuse offenders. *Family Relations* 44(4):478–488.

Miner, M.H., and Crimmins, C.L.S. 1995. Adolescent sex offenders: Issues of etiology and risk factors. In *The Sex Offender: Vol. 1. Corrections, Treatment and Legal Practice,* edited by B.K. Schwartz and H.R. Cellini. Kingston, NJ: Civic Research Institute, pp. 9.1–9.15.

Miner, M.H., Siekert, G.P., and Ackland, M.A. 1997. *Evaluation: Juvenile Sex Offender Treatment Program, Minnesota Correctional Facility—Sauk Centre.* Final report—Biennium 1995–1997. Minneapolis, MN: University of Minnesota, Department of Family Practice and Community Health, Program in Human Sexuality.

Morenz, B., and Becker, J.V. 1995. The treatment of youthful sexual offenders. *Applied and Preventive Psychology* 4(4):247–256.

National Adolescent Perpetrator Network. 1988. Preliminary report from the National Task Force on Juvenile Sexual Offending. *Juvenile and Family Court Journal* 38(2):1–67.

National Adolescent Perpetrator Network. 1993. The revised report from the National Task Force on Juvenile Sexual Offending. *Juvenile and Family Court Journal* 44(4):1–120.

O'Brien, M. 1991. Taking sibling incest seriously. In *Family Sexual Abuse,* edited by M.Q. Patton. Newbury Park, CA: Sage Publications, pp. 75–92.

Pithers, W.D., Gray, A., Busconi, A., and Houchens, P. 1998a. Caregivers of children with sexual behavior problems: Psychological and familial functioning. *Child Abuse and Neglect* 22(2):129–141.

Pithers, W.D., Gray, A., Busconi, A., and Houchens, P. 1998b. Children with sexual behavior problems: Identification of five distinct child types and related treatment considerations. *Child Maltreatment* 3(4):384–406.

Prentky, R. 1995. A rationale for the treatment of sex offenders: Pro bono publico. In *What Works: Reducing Reoffending Guidelines from Research and Practice,* edited by J. McGuire. New York, NY: John Wiley and Sons Ltd., pp. 153–170.

Prentky, R. 1997. Juvenile sex offenders: Assessment, classification and treatment needs. Presentation sponsored by the Child Abuse Action Network, Topsham, ME, November 1997.

Prentky, R., and Burgess, A.W. 1990. Rehabilitation of child molesters: A cost-benefit analysis. *American Journal of Orthopsychiatry* 60(1):108–117.

Prentky, R., and Edmunds, S.B. 1997. *Assessing Sexual Abuse: A Resource Guide for Practitioners.* Brandon, VT: Safer Society Press.

Prentky, R., Harris, B., Frizzell, K., and Righthand, S. 2000. An actuarial procedure for assessing risk in juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment* 12(2):71–93.

Prentky, R.A., Lee, A.F.S., Knight, R.A., and Cerce, D. 1997. Recidivism rates among child molesters and rapists: A methodological analysis. *Law and Human Behavior* 21(6):635–660.

Quinsey, V.L., Rice, M.E., and Harris, G.T. 1995. Actuarial prediction of sexual recidivism. *Journal of Interpersonal Violence* 10(1):85–105.

Rasmussen, L.A. 1999. Factors related to recidivism among juvenile sexual offenders. *Sexual Abuse: A Journal of Research and Treatment* 11(1):69–85.

Ray, J., Smith, V., Peterson, T., Gray, J., Schaffner, J., and Houff, M. 1995. A treatment program for children with sexual behavior problems. *Child and Adolescent Social Work Journal* 12(5):331–343.

Ray, J.A., and English, D.J. 1995. Comparison of female and male children with sexual behavior problems. *Journal of Youth and Adolescence* 24(4):439–451.

Righthand, S., Hennings, R., and Wigley, P. 1989. *Young Sex Offenders in Maine.* Portland, ME: University of Southern Maine, Public Policy and Management Program, Human Services Development Institute, Committee on Child Sex Abuse: Research Task Force.

Ross, J.E., and Villier, M.P. 1993. Safety considerations in developing an adolescent sex offender program in residential treatment. In *Sexual Abuse and Residential Treatment,* edited by W.C. Braga and R. Shimmer. Binghamton, NY: Haworth Press, pp. 37–47.

Ryan, G., Miyoshi, T.J., Metzner, J.L., Krugman, R.D., and Fryer, G.E. 1996. Trends in a national sample of sexually abusive youths. *Journal of the American Academy of Child and Adolescent Psychiatry* 35(1):17–25.

Salekin, R.T., Rogers, R., and Sewell, K.W. 1996. A review and meta-analysis of the Psychopathy Checklist and Psychopathy Checklist-Revised: Predictive validity of dangerousness. *Clinical Psychology: Science and Practice* 3(3):203–215.

Schram, D.D., Milloy, C.D., and Rowe, W.E. 1991. *Juvenile Sex Offenders: A Follow Up Study of Reoffense Behavior.* Olympia, WA: Washington State Institute for Public Policy, Urban Policy Research and Cambie Group International.

Serin, R.C. 1996. Violent recidivism in criminal psychopaths. *Law and Human Behavior* 20(2):207–217.

Serin, R.C., Malcolm, P.B., Khanna, A., and Barbaree, H.E. 1994. Psychopathy and deviant sexual arousal in incarcerated sexual offenders. *Journal of Interpersonal Violence* 9(1):3–11.

Sipe, R., Jensen, E.L., and Everett, R.S. 1998. Adolescent sexual offenders grown up: Recidivism in young adulthood. *Criminal Justice and Behavior* 25(1):109–124.

Smith, G., and Fischer, L. 1999. Assessment of juvenile sexual offenders: Reliability and validity of the Abel Assessment for Interest in Paraphilias. *Sexual Abuse: A Journal of Research and Treatment* 11(3):207–216.

Smith, H., and Israel, E. 1987. Sibling incest: A study of dynamics of 25 cases. *Child Abuse and Neglect* 11(1):101–108.

Smith, W.R., and Monastersky, C. 1986. Assessing juvenile sexual offenders' risk for reoffending. *Criminal Justice and Behavior* 13(2):115–140.

Spaccarelli, S., Bowden, B., Coatsworth, J.D., and Kim, S. 1997. Psychosocial correlates of male sexual aggression in a chronic delinquent sample. *Criminal Justice and Behavior* 24(1):71–95.

Stermac, L., and Sheridan, L. 1993. The developmentally disabled adolescent sex offender. In *The Juvenile Sex Offender,* edited by H.E. Barbaree, W.L. Marshall, and S.M. Hudson. New York, NY: Guilford Press, pp. 235–242.

Stevenson, H.C., and Wimberley, R. 1990. Assessment of treatment impact of sexually aggressive youth. *Journal of Offender Counseling, Services and Rehabilitation* 15(2):55–68.

Swenson, C.C., Henggeler, S.W., Schoenwald, S.K., Kaufman, K.L., and Randall, J. 1998. Changing the social ecologies of adolescent sexual offenders: Implications of the success of multisystemic therapy in treating serious antisocial behavior in adolescents. *Child Maltreatment* 3(4):330–338.

Tolan, P., and Guerra, N. 1994. *What Works in Reducing Adolescent Violence: An Empirical Review of the Field.* Boulder, CO: University of Colorado, Institute for Behavioral Sciences, Center for the Study and Prevention of Violence.

Tolan, P.H., and Gorman-Smith, D. 1998. Development of serious and violent offending careers. In *Serious and Violent Juvenile Offenders: Risk Factors and Successful Interventions,* edited by R. Loeber and D.P. Farrington. Thousand Oaks, CA: Sage Publications, pp. 68–85.

Travin, S., Cullen, K., and Protter, B. 1990. Female sex offenders: Severe victims and victimizers. *Journal of Forensic Sciences* 35(1):140–150.

Utah Task Force of the Utah Network on Juveniles Offending Sexually. 1996. *The Utah Report on Juvenile Sex Offenders.* Salt Lake City, UT: Utah Task Force of the Utah Network on Juveniles Offending Sexually.

Webster, C.D., Douglas, K.S., Eaves, D., and Hart, S.D. 1997. Assessing risk of violence to others. In *Impulsivity: Theory, Assessment, and Treatment,* edited by C.D. Webster and M.A. Jackson. New York, NY: Guilford Press, pp. 251–277.

Weinrott, M. 1996. *Juvenile Sexual Aggression: A Critical Review.* Boulder, CO: University of Colorado, Institute for Behavioral Sciences, Center for the Study and Prevention of Violence.

Weinrott, M. 1998a. Empirically-based treatment interventions for juvenile sex offenders. Presentation sponsored by the Child Abuse Action Network and the State Forensic Service, Augusta, ME, August 1998.

Weinrott, M. 1998b. Recidivism among juvenile sex offenders: Are favorable outcomes only favorable when therapy matters? Handout from Empirically-based treatment interventions for juvenile sex offenders. Presentation sponsored by the Child Abuse Action Network and the State Forensic Service, Augusta, ME, August 1998.

Weinrott, M., Riggan, M., and Frothingham, S. 1997. Reducing deviant arousal in juvenile sex offenders using vicarious sensitization. *Journal of Interpersonal Violence* 12(5):704–728.

Wieckowski, E., Hartsoe, P., Mayer, A., and Shortz, J. 1998. Deviant sexual behavior in children and young adolescents: Frequency and patterns. *Sexual Abuse: A Journal of Research and Treatment* 10(4):293–304.

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