C e n t e r F o r S e x O f f e n d e r M a n a g e m e n t

Understanding Juvenile Sexual Offending Behavior: Emerging Research, Treatment Approaches and Management Practices

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Introduction

Juveniles commit a significant number of the sexual assaults against children and women in this country. The onset of sexual offending behavior in these youth can be linked to numerous factors reflected in their experiences, exposure, and/or developmental deficits. Emerging research suggests that, as in the case of adult sex offenders, a meaningful distinction can be made between youth who target peers or adults and those who offend against children. However, juveniles who sexually offend are distinct from their adult counterparts. Youth who commit sexual offenses are not necessarily "little adults;" many will not continue to offend sexually. This is a formative area of research; while there is an ever-increasing body of knowledge regarding the etiologies of dysfunction and aggression, there remains a tremendous need for additional data to understand the etiology of juvenile sexual offending.

The purpose of this brief is to discuss the current state of research on sexually abusive youth, legislative trends, and promising approaches to the treatment and supervision of these youth.

Research Developments

CHARACTERISTICS OF JUVENILE SEXUAL ABUSE

Sexual aggression perpetrated by young people has been a growing concern in the United States over the past decade. Currently, it is estimated that juveniles account for up to one-fifth of all rapes[1] and almost one-half of all cases of child molestation[2] committed each year.[3]

Adolescents age 13 to 17 account for the vast majority of cases of rape and child molestation perpetrated by minors.[4] The majority of incidents of juvenile sexual aggression involve male perpetrators.[5] However, a number of clinical studies also point to prepubescent youths and females engaging in sexually abusive behaviors. Although racial and socioeconomic differences may be over represented in certain settings (e.g., juvenile justice), juveniles referred for treatment in a variety of environments reflect the same racial, religious, and socioeconomic distribution as the general population of the United States.[6]

A number of etiological factors (risk factors) have been identified to help explain the developmental origin of sexual offending. Factors receiving the most attention are abusive experiences and exposure to aggressive role models. Other factors in focus are substance abuse and exposure to pornography; however, these are seen more as disinhibitors than as causal influences.

The Effects of Physical and Sexual Abuse

Recent studies show that rates of abusive histories vary widely for sexually abusive youth. A history of physical abuse has been found in 20 to 50 percent of these youth; a history of sexual abuse has been found in 40 to 80

[1] In 1995, youth were involved in 15 percent of all forcible rapes that resulted in arrest; approximately 18 adolescents per 100,000 (ages 10 to 17) were arrested for forcible rape in 1995 (Sickmund et al, 1997).

[2] Approximately 16,100 adolescents were arrested for sexual offenses in 1995 (excluding rape and prostitution). This is approximately 3 times the number of youths arrested for forcible rape (Sickmund et al, 1997).

[3] Barbaree, H.E., Hudson, S.M., & Seto, M.C. (1993). *Sexual Assault in Society: The Role of the Juvenile Offender*. In H.E. Barbaree, W.L. Marshall & S.W. Hudson (Eds.), The Juvenile Sex Offender, pp. 10-11. Becker, J.V., Harris, C.D., & Sales, B.D. (1993). *Juveniles Who Commit Sexual Offenses: A Critical Review of Research*. In G.C.N. Hall, R. Hirschman, J. Graham & M. Zaragoza (Eds.), Sexual Aggression: Issues in Etiology and Assessment, Treatment, and Policy. Washington, DC: Taylor and Francis. Sickmund, M., Snyder, H.N., & Poe-Yamagata, E. (1997). *Juvenile Offenders and Victims: 1997 Update on Violence*. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention.

[4] Davis, G.E., & Leitenberg H. (1987). *Adolescent Sex Offenders*. Psychological Bulletin (101), pp. 417-427.

[5] Sickmund et al., 1997.

[6] Ryan, G., Miyoshi, T.J., Metzner, J.L., Krugman, M.D., & Fryer, G.E. (1996). *Trends in a National Sample of Sexually Abusive Youths.* Journal of the American Academy of Child and Adolescent Psychiatry (35), pp. 17-25.

Established in June 1997, CSOM's goal is to enhance public safety by preventing further victimization through improving the management of adult and juvenile sex offenders who are in the community. A collaborative effort of the Office of Justice Programs, the National Institute of Corrections, and the State Justice Institute, CSOM is administered by the Center for Effective Public Policy and the American Probation and Parole Association.

percent of sexually abusive youth.[7] Rates of physical abuse and sexual victimization are even higher in samples of prepubescent and young female sexual abusers.[8] Research suggests that age of onset, number of incidents of abuse, the period of time elapsing between the abuse and its first report, as well as perceptions of familial responses to awareness of the abuse are all relevant in understanding why some sexually abused youths go on to commit sexual assaults while others do not.[9]

The influence of abusive experiences is considered multi-faceted and includes effects related to both Post-Traumatic Stress Disorder and modeling.[10] Symptoms of Post-Traumatic Stress Disorder have been observed in a number of youths with sexual behavior disorders, especially children ages 13 and younger and females. These symptoms include recurrent and intrusive recollections of past traumatic events and increased levels of irritability and anger. Youths who have directly experienced or witnessed sexual abuse may imitate the behavior of the aggressive role model(s) in their interactions with others.

The presence of child maltreatment—whether neglect, physical abuse, sexual abuse, or other forms of victimization—may eventually prove to be a significant predictor of sexual offending behavior.

Exposure to Aggressive Role Models

Studies show that male child witnesses to domestic violence tend to engage in externalizing behaviors (the acting-out of psychological conflict or tension), including acts of interpersonal aggression, more than their female counterparts.[11] Exposure to family violence is linked to the likelihood of sexually offending as an adolescent, as well as the severity of psychosexual disturbance.[12] The effects of exposure may be cumulative, as well as interactive with other developmental experiences, such as child abuse and neglect.[13] Recent studies suggest that exposure to severe community violence (e.g., murders) may also increase the likelihood of engaging in violent and antisocial behavior.[14]

Substance Abuse and Exposure to Pornography

While there is strong research to support the association between violent crime and alcohol use, the association between sexual offending and substance abuse is not fully established. Estimates of the extent of substance abuse vary widely for the population of youth who sexually offend.[15] The influence of pornography on the developing male's potential for sexual offending is an issue of similar controversy. One recent study found that sexually abusive youth were exposed to pornographic material at younger ages on the average, and to "harder core" pornography, than either status offenders or violent non-sex offending youths.[16] Research in these areas is lacking and clearly, juvenile sexual offending is far more complex than simple exposure to pornography or substance abuse.

Developmental Progression

While sexual aggression may emerge early in the developmental process, there is no evidence to suggest that the majority of sexually abusive youth become adult sex offenders. Recidivism rates for these youth may have been exaggerated by a reliance on retrospective research studies (studies that examine historical data), which can overstate the strength of correlations. Longitudinal studies (studies that examine current data), which tend to be more reliable, suggest that aggressive behavior in youths often does not continue into adulthood, although some portion of those who commit rape may continue to abuse.[17]

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[7] Hunter, J.A. & Becker, J.V. (1998). *Motivators of Adolescent Sex Offenders and Treatment Perspectives*. In J. Shaw (Ed.), Sexual Aggression. Washington, DC: American Psychiatric Press, Inc. Kahn, T.J. & Chambers, H.J. (1991). *Assessing Reoffense Risk with Juvenile Sexual Offenders*. Child Welfare (19), pp. 333-345.

[8] Gray, A., Busconi, A., Houchens, P., & 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), pp. 267-290. Mathews, R., Hunter, J.A., & Vuz, J. (1997). *Juvenile Female Sexual Offenders: Clinical Characteristics and Treatment Issues*. Sexual Abuse: A Journal of Research and Treatment (9), pp. 187-199.

[9] Hunter, J.A. & Figueredo, A.J. (in press). *The Influence of Personality and History of Sexual Victimization in the Prediction of Offense Characteristics of Juvenile Sex Offenders*. Behavior Modification.

[10] Freeman-Longo, R.E. (1986). *The Impact of Sexual Victimization on Males*. Child Abuse and Neglect (10), pp. 411-414. Gil, E. & Johnson, T.C. (1992). *Assessment and Treatment of Sexualized Children and Children Who Molest*. Rockville, MD: Launch Press.

[11] Stagg, V., Wills, G.D., & Howell, M. (1989). *Psychopathy in Early Child Witnesses of Family Violence*. Topics in Early Childhood Special Education (9), pp. 73-87.

[12] Fagan, J. & Wexler, S. (1988). *Explanations of Sexual Assault among Violent Delinquents*. Journal of Adolescent Research (3), pp. 363-385. Smith, W.R. (1988). *Delinquency and Abuse among Juvenile Sexual Offenders*. Journal of Interpersonal Violence (3), pp. 400-413.

[13] O'Keefe, M. (1994). *Linking Martial Violence, Mother—Child/Father—Child Aggression, and Child Behavior Problems*. Journal of Family Violence (9), pp. 63-78.

[14] Johnson-Reid, M. (1998). *Youth Violence and Exposure to Violence in Childhood: An Ecological Review*. Aggression and Violent Behavior (3), pp. 159-179.

[15] Lightfoot, L.O. & Barbaree, H.E. (1993). *The Relationship between Substance Use and Abuse and Sexual Offending in Adolescents*. In H.E. Barbaree, W.L. Marshall, & S.W. Hudson (Eds.), The Juvenile Sex Offender, pp. 203-224. Guilford Press, NY.

[16] Ford, M.E. & Linney, J.A. (1995). *Comparative Analysis of Juvenile Sexual Offenders, Violent Nonsexual Offenders, and Status Offenders*. Journal of Interpersonal Violence (10), pp. 56-70.

[17] Elliott, D.S. (1994). *The Developmental Course of Sexual and Non-Sexual Violence: Results from a National Longitudinal Study*. Paper presented at the meeting of the Association for the Treatment of Sexual Abusers 13th Annual Research and Treatment Conference, San Francisco, CA. Loeber, R. & Stouthamer-Loeber, M. (1998). *Development of Juvenile Aggression and Violence: Some Common Misconceptions and Controversies*. American Psychologist (53), pp. 242-259.

Other Characteristics Common to Sexually Abusive Youth

Sexually abusive youth share other common characteristics, including:

- high rates of learning disabilities and academic dysfunction (30 to 60 percent);[18]
- the presence of other behavioral health problems, including substance abuse and conduct disorders (up to 80 percent have some diagnosable psychiatric disorder);[19] and
- observed difficulties with impulse control and judgment.[20]

The following table outlines some of the common characteristics found in youth who sexually offend:

Table 1.
Characteristics of Sexually Abusive Youth

- Typically adolescents, age 13 to 17.
- Mostly male perpetrators.
- Difficulties with impulse control and judgment.
- Up to 80 percent have a diagnosable psychiatric disorder.
- 30 to 60 percent exhibit learning disabilities and academic dysfunction.
- 20 to 50 percent have histories of physical abuse.
- 40 to 80 percent have histories of sexual abuse.

TYPOLOGY

The clinical and criminal dimensions of juvenile male sexual abusers often vary. As with their adult counterparts, juvenile sexual abusers fall primarily into two major types: those who target children and those who offend against peers or adults. The distinction between these two groups is based on the age difference between the victim and the perpetrator (child perpetrators are those who target children five[21] or more years younger than themselves).

Table 2 (see page 4) examines distinctions in characteristics between these two groups of sexually abusive youth.

Deviant Sexual Interests

A minority of sexually abusive youth manifest established paraphilic (deviant) sexual arousal and interest patterns. These arousal and interest patterns are recurrent and intense, and relate directly to the nature of the sexual behavior problem (e.g., sexual arousal to young children). Deviant sexual arousal is more clearly established as a motivator of adult sexual offending, particularly as it relates to pedophilia. A small subset of juveniles who sexually offend against children may represent cases of early onset pedophilia. Research has demonstrated that the highest levels of deviant sexual arousal are found in juveniles who exclusively target young male children, specifically when penetration is involved.[22] In general, the sexual arousal patterns of sexually abusive youth appear more changeable than those of adult sex offenders, and relate less directly to their patterns of offending behavior.[23]

[18] Awad, G.A. & Saunders, E.B. (1991). *Male Adolescent Sexual Assaulters: Clinical Observations*. Journal of Interpersonal Violence (6), pp. 446-460. Hunter, J.A. & Goodwin, D.W. (1992*). The Utility of Satiation Therapy in the Treatment of Juvenile Sexual Offenders: Variations and Efficacy*. Annals of Sex Research (5), pp. 71-80. Epps, K. (1991). *The Residential Treatment of Adolescent Sex Offenders*. Issues in Criminological and Legal Psychology (1), pp. 58-67.

[19] Kavoussi, R.J., Kaplan, M., & Becker, J.V. (1988). *Psychiatric Diagnosis in Adolescent Sex Offenders*. Journal of the American Academy of Child and Adolescent Psychiatry (27), pp. 241-243.

[20] Smith, W.R., Monastersky, C., & Deishner, R.M. (1987). *MMPI-Based Personality Types among Juvenile Sexual Offenders*. Journal of Clinical Psychology (43), pp. 422-430. Epps, 1991. Vizard, E., Monck, E., & Misch, P. (1995). *Child and Adolescent Sex Abuse Perpetrators: A Review of the Research Literature*. Journal of Child Psychology and Psychiatry (36), pp. 731-756.

[21] Some state laws refer to a three or four year age difference between the perpetrator and child victim.

[22] Hunter, J.A. & Becker, J.V. (1994). *The Role of Deviant Sexual Arousal in Juvenile Sexual Offending: Etiology, Evaluation, and Treatment*. Criminal Justice and Behavior (21), pp. 132-149. See also: Marshall, W.L., Barbaree, H.E., & Eccels, A. (1991). *Early Onset and Deviant Sexuality in Child Molesters*. Journal of Interpersonal Violence (6), pp. 323-336.

[23] Hunter & Becker, 1994. Hunter, J.A., Goodwin, D.W., & Becker, J.V. (1994). *The Relationship between Phallometrically Measured Deviant Sexual Arousal and Clinical Characteristics in Juvenile Sexual Offenders*. Behavior Research and Therapy (32), pp. 533-538.

Table 2. Comparing Two Sub-Groups of Sexually Abusive Youth		
Characteristics:	**Offend Against Peers or Adults**	**Offend Against Children**
Victims	▪ Predominantly assault females. ▪ Assault mostly strangers or acquaintances.[25]	▪ Females victimized at slightly higher rates. ▪ Nearly half assault at least one male. ▪ Up to 40 percent of victims are either siblings or relatives.[26]
Offense Patterns	▪ More likely to commit in conjunction with other criminal activity. ▪ More likely to commit offenses in public areas.[27]	▪ Reliance on opportunity and guile, particularly when victim is a relative. ▪ Trick child by using bribes or threatening loss of relationship.[28]
Social and Criminal History	▪ More likely to have histories of non-sexual criminal offenses. ▪ Generally delinquent and conduct-disordered.[29]	▪ Deficits in self-esteem and social competency are common. ▪ Often lack skills and attributes necessary for forming and maintaining healthy interpersonal relationships.[30]
Behavior Patterns	▪ Display higher levels of aggression and violence.[31] ▪ More likely to use weapons and cause injuries to their victims.[32]	▪ Frequently display signs of depression.[33] ▪ Youths with severe personality and/or psychosexual disturbance may display high levels of aggression and violence.[34]

TREATMENT RESEARCH

While funding and ethical issues have made it difficult to conduct carefully controlled treatment outcome studies, a number of encouraging clinical reports on the treatment of sexually abusive youth have been published.[24] While these studies are not definitive, they provide support for the belief that the majority of sexually abusive youth are amenable to, and can benefit from, treatment.

Multisystemic Therapy

In what is perhaps the best controlled study to date, Borduin, Henggeler, Blaske, and Stein compared "Multisystemic Therapy" (MST) with individual therapy in the outpatient treatment of 16 juvenile sex abusers.[35]

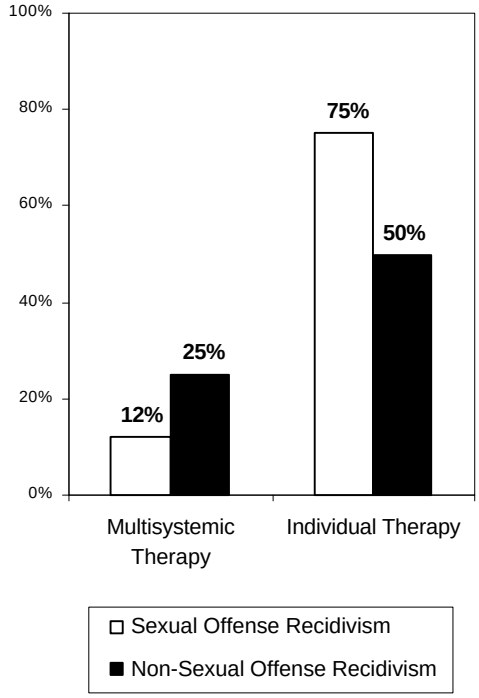
MST is an intensive family- and community-based treatment that addresses the multiple factors of serious antisocial behavior in juvenile abusers. Treatment can involve any combination of the individual, family, and extrafamilial (e.g., peer, school, or neighborhood) factors. MST promotes behavior change in the youth's natural environment, using the strengths of the youth's family, peers, school, and neighborhood to facilitate change.

In this study, rearrest records were used as a measure of sexual and non-sexual recidivism; the groups were compared at a three-year follow-up interval. Results revealed that youths receiving multisystemic therapy had recidivism rates of 12.5 percent for sex offenses and 25 percent for non-sex offenses, while those receiving

[24] Becker, J.V. & Hunter, J.A. (1997). *Understanding and Treating Child and Adolescent Sexual Offenders*. In T.H. Ollendick and R.J. Prinz (Eds.), Advances in Clinical Child Psychology (19). New York: Plenum Press.
[25] Hunter, J.A., Hazelwood, R.R., Slesinger, D. (in press). *Juvenile Perpetrated Sexual Crimes: Patterns of Offending and Predictors of Violence*. Journal of Family Violence.
[26] Ibid.
[27] Ibid.
[28] Ibid. Kaufman, K.L., Hilliker, D.R., & Daleiden, E.L. (1996). *Subgroup Differences in the Modus Operandi of Adolescent Sexual Offenders*. Child Maltreatment (1), pp. 17-24.
[29] Ibid. Richardson, G., Kelly, T.P., Bhate, S.R., & Graham, F. (1997). *Group Differences in Abuser and Abuse Characteristics in a British Sample of Sexually Abusive Adolescents*. Sexual Abuse: A Journal of Research and Treatment (9), pp. 239-257.
[30] Awad, G.A. & Saunders, E.B. (1989). *Adolescent Child Molesters: Clinical Observations*. Child Psychiatry and Human Development (19), pp. 195-206. Monto, M., Zgourides, G., & Harris, R. (1998). *Empathy, Self-Esteem, and the Adolescent Sexual Offender*. Sexual Abuse: A Journal of Research and Treatment (10), pp. 127-140.
[31] Ibid.
[32] Ibid.
[33] Becker, J.V., Kaplan, M.S., Tenke, C.E., & Tartaglini, A. (1991). *The Incidence of Depressive Symptomatology in Juvenile Sex Offenders with a History of Abuse*. Child Abuse and Neglect (15), pp. 531-536.
[34] Becker, J.V. & Hunter, J.A. (1993). *Aggressive Sex Offenders*. Child and Adolescent Psychiatric Clinics of North America (2), pp. 477-487.
[35] Borduin, C.M., Henggeler, S.W., Blaske, D.M., & Stein, R.J. (1990). *Multisystemic Treatment of Adolescent Sexual Offenders*. International Journal of Offender Therapy and Comparative Criminology (34), pp. 105-114.

individual therapy had recidivism rates of 75 percent for sex offenses and 50 percent for non-sex offenses.

"Multisystemic" Therapy Recidivism



Other Treatment Research

Program evaluation data suggests that the sexual recidivism rate for juveniles treated in specialized programs ranges from approximately 7 to 13 percent over follow-up periods of two to five years.[36] Furthermore, juveniles appear to respond well to cognitive/behavioral and/or relapse prevention treatment, with recidivism rates of approximately seven percent through follow-up periods of more than five years.[37] Studies suggest that rates of non-sexual recidivism are generally higher (25 to 50 percent).[38] Findings from outcome studies on adult offenders show higher sexual recidivism rates for individuals who fail to successfully complete treatment programs.[39]

In a recently conducted study, Hunter and Figueredo found that as many as 50 percent of youths entering a community-based treatment program were expelled during the first year of their participation.[40] Those who failed the program had higher overall levels of sexual maladjustment, as measured on assessment instruments, and were judged to be at greater long-term risk for sexual recidivism.

Policy Development Issues

TRENDS IN JUVENILE JUSTICE

The rise in juvenile perpetrated violence over the past decade has resulted in legislation designed to enhance public safety and raise the level of accountability of juveniles in the criminal justice system.[41] Substantive changes have been made in legal statutes or regulatory policy in over 90 percent of the states. These reforms include changes related to:

- juvenile court waivers;
- sentencing guidelines;
- record confidentiality;
- community notification;
- registration requirements for sex offenders; and
- correctional programming.

The number of delinquency cases waived to adult criminal courts increased by 71 percent between 1985 and 1994.[42] The age at which a juvenile may be tried as an adult has been lowered in over half of the states. Twenty jurisdictions[43] have no minimum age restriction for trying a juvenile as an adult for certain serious crimes.[44] Legislative changes have also made it more likely that once a juvenile is convicted of a crime in the adult courts, he or she will serve at least some minimum sentence.[45] Presently, more than half of the states[46] permit public access to juvenile court records with some age and offense restrictions, while eleven states[47] permit

[36] Becker, J.V. (1990). *Treating Adolescent Sexual Offenders*. Professional Psychology: Research and Practice (21), pp. 362-265.
[37] Alexander, M.A. (1999). *Sexual Offender Treatment Efficacy Revisited*. Sexual Abuse: A Journal of Research and Treatment (11), pp. 101-116.
[38] Becker, 1990. Kahn & Chambers, 1991. Schram, D.D., Milloy, C.D., & Rowe, W.E. (1991). *Juvenile Sex Offenders: A Follow-Up Study of Reoffense Behavior*. Unpublished manuscript.
[39] Marques, J.K., Day, D.M., Nelson, C., & West, M.A. (1994). *Effects of Cognitive Behavioral Treatment on Sex Offender Recidivism: Preliminary Results of a Longitudinal Study*. Criminal Justice and Behavior (21), pp. 28-54.
[40] Hunter, J.A. & 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), pp. 49-68.
[41] See Hunter, J.A. & Lexier, L.J. (1998). *Ethical and Legal Issues in the Assessment and Treatment of Juvenile Sex Offenders*. Child Maltreatment (3), pp. 340-349.
[42] Szymanski, National Center for Juvenile Justice (1998). *Frequent Questions and Answers*. National Center for Juvenile Justice. (Available from the National Center for Juvenile Justice, 710 Fifth Avenue, Pittsburgh, PA 15219.)
[43] Alaska, Arizona, Delaware, the District of Columbia, Florida, Georgia, Maine, Maryland, Nebraska, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Washington, West Virginia, and Wisconsin.
[44] Szymanski, 1998.
[45] Office of Juvenile Justice and Delinquency Prevention, 1997.
[46] Colorado, Delaware, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, New Jersey, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.
[47] Arizona, Arkansas, Colorado, Florida, Iowa, Michigan, Montana, Nevada, New Mexico, Texas, and Washington.

public juvenile hearings with no age or crime restrictions.[48]

Registration and Community Notification Laws

The registration and tracking of individuals convicted of violent sex crimes or crimes against minors began with the passing of the 1994 Jacob Wetterling Act. The Wetterling Act was amended in 1996, with the passage of "Megan's Law," which requires (as opposed to authorizing) state and local law enforcement agencies to release information that is necessary to protect the public concerning a specific person required to register. The Pam Lychner Sexual Offender Tracking and Identification Act of 1996 created criteria for mandatory lifetime registration of highly-dangerous sex offenders, penalties for failure to register, and a requirement that the FBI create a national sex offender registry to assist law enforcement in tracking sex offenders when they move. Under federal guidelines, states are not required to register juveniles who are adjudicated delinquent for a sex crime. However, states may require registration for these youth if they wish to do so. Juveniles convicted as adults are required to register under provisions of these guidelines.[49] At least 27 states have enacted registration laws for juveniles convicted (or adjudicated) of sex crimes.[50] In some states, juveniles are subjected to the same registration requirements as adult sex offenders. In others, juveniles register until they reach a certain age (e.g., 18 or 21); in some instances, the court may require continued registration as an adult sex offender once a juvenile reaches that age.

Idaho's Juvenile Registry

Idaho maintains a registry of juveniles adjudicated of sexual offenses, separate from the adult registry. This registry is open to public inspection, and it is shared with the superintendent of public instruction who then notifies public and private schools regarding the enrollment of any registered juveniles. In Idaho, juveniles are required to register annually until they reach the age of 21, at which time a prosecutor can file a petition to have the youth transferred to the adult registry. If no petition is filed, the juvenile is deleted from the registry.

[48] Szymanski, 1998.

[49] U.S. Department of Justice (January 5, 1999). *Megan's Law; Final Guidelines for the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act, as Amended*. Federal Register, vol. 64 (2), pp. 572-587.

[50] Arizona, California, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Jersey, North Carolina, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, and Wisconsin.

Promising Approaches to Intervention

The number of programs providing treatment services to juvenile sex abusers more than doubled between 1986 and 1992, and continues to climb. This growth reflects both increased societal concern about rising rates of juvenile sex offenses and the professional belief that early intervention helps to stem the emergence of chronic patterns of sexual offending. The following is a review of issues essential to the development of successful community-based treatment programming for sexually abusive youth.

COORDINATION BETWEEN THE CRIMINAL JUSTICE SYSTEM AND TREATMENT PROVIDERS

Most treatment specialists believe that successful programming for sexually abusive youth requires a coordinated effort between criminal justice system actors and treatment providers.[51] For juveniles to productively participate in treatment programming, they must be willing to address their problems and comply with therapeutic directives. Adjudication and supervision typically prove useful in ensuring client accountability and compliance with treatment, as well as a means to prevent future victimization.

Clinical experience has demonstrated that the suspension of the youth's sentence contingent upon his or her successful completion of a treatment program is a particularly effective motivator. Under collaborative arrangements, the treatment specialist provides ongoing progress reports to the courts. Those youth who fail to comply with program expectations can be brought back before the court for review.

Supervision

To date, no studies have been conducted that clearly identify which supervision strategies are most effective with these youth. However, research on adult sex offender supervision suggests that model management strategies involve: intensive supervision and sex offense specific treatment; interagency collaboration, multidisciplinary teams, and the specialization of supervision and treatment staff; the use of the polygraph to monitor therapy and compliance with supervision conditions; and program monitoring and evaluation, which ensure prescribed policies and practices are

[51] National Task Force on Juvenile Sexual Offending (1993). *Final Report*. A function of: National Adolescent Perpetration Network, C. H. Kempe National Center, University of Colorado Health Sciences Center.

delivered as planned.[52] However, there has been little research on the application of adult conditions to juveniles. Too little is yet known about young perpetrators to apply adult standards to them.

The Role of Supervision Officers

In many programs, parole and probation officers play an integral role in assisting treatment providers by addressing critical issues and supervising youths' activities in the home and community. Parole and probation officers help evaluate the extent to which clients are productively participating in the treatment program and complying with court and therapeutic directives. They provide an additional link between the provider and youths' families, and often assist therapists in impressing upon families the importance of their involvement in the youths' rehabilitative programming. In some instances, parole and probation officers participate directly in the delivery of therapeutic services as co-therapists in treatment groups.[53] While there is little consensus among the treatment community about the proper role of supervision officers in the treatment of young sexual abusers, supervision officers should, at a minimum, communicate and collaborate with treatment providers.

Alternative Disposition in Washington State

In Washington State, the court has the option to order a treatment sentence for most sexually abusive youth. Under the Special Sex Offender Disposition Alternative (SSODA), the judge can suspend the offender's sentence, place the offender on community supervision for up to two years, and require the juvenile to participate in treatment with a state-certified therapist. The state pays the cost of treatment. If an offender does not comply with sentence conditions, or if the judge determines that the juvenile is not making adequate progress in treatment, the disposition may be revoked and a determinate sentence imposed. The law allows courts to remove the registration requirement for any juvenile after he or she has fulfilled sentence requirements [Lieb, R. (1998). Sex Offenses in Washington State: 1998 Update. Washington State Institute for Public Policy, Olympia, WA].

Pilot Program: Jefferson County, Colorado

In Jefferson County, when juveniles are arrested for a sex offense, they are taken to an assessment center and administered a risk-screening instrument. This instrument determines whether these youth will be detained or allowed to remain in the community, either at home or in another alternative placement such as foster care. The assessment center works with the family and youth, and can refer family members to community counseling, if necessary. Under this process, treatment can start before sentencing occurs.

Juveniles start probation at the highest level of supervision. They are sentenced to probation for a maximum of two years. Youth participate in a risk and protective factor process to determine the most applicable treatment. Probation officers meet frequently with treatment providers, and in some instances, they may attend treatment sessions about once a month to observe first hand their clients' progress in treatment. Juveniles are also administered polygraphs and plethysmographs when therapists or probation officers feel they are needed. Conditions of probation include the need to comply with polygraph or plethysmograph assessment if deemed useful by the treatment provider.

Jefferson County also has established a county-wide case management team for juveniles, consisting of pre-trial and probation supervision staff, treatment providers, a child advocacy center representatives, staff from the prosecutor's office and the schools. This team meets monthly to assess each case and work together to ensure that both clients and victims are receiving optimal service.

In May 1998, the juvenile supervision guidelines developed by the Jefferson County unit were recommended for use throughout Colorado.

Typically, parole and probation officers provide an essential case management function. This includes analysis (sometimes with the help of social services) of the appropriateness of youth receiving in-home treatment and of the need for supplemental community programming, such as community service projects. As case managers, parole/probation officers also facilitate appropriate communications between treatment providers and other community agencies, such as school officials involved in the youths' overall care.

ASSESSMENT

Careful screening is critical to the success of community-based programming. Ideally, this assessment reflects the careful consideration of the danger that the perpetrator presents to the community, the severity of psychiatric and psychosexual problems, and the juvenile's amenability to treatment. The latter issues involve an

[52] English, K., Pullen, S., Jones, L, & Krauth, B. (1996). *A Model Process: A Containment Approach*. In English, K., Pullen, S., and Jones, L. (Eds.), Managing Adult Sex Offenders: A Containment Approach. American Probation and Parole Association, Lexington, KY.

[53] This typically occurs in cases where the probation officer has received additional training in the treatment of sex offenders. For further information, contact the Association for the Treatment of Sexual Abusers (ATSA), Connie Isaac, Executive Director, 10700 SW Beaverton-Hillsdale Hwy., Suite 26, Beaverton, OR 97005-3035, (503) 643-1023, fax (503) 643-5084, e-mail: connie@atsa.com.

assessment of the youth's level of accountability for his or her sex offenses, motivation for change, and receptivity to professional help. Professionals who are experienced working with sexually abusive youth should conduct these evaluations. Programs should not compromise community safety by admitting youths who are more aggressive and violent, those who have psychiatric problems that are beyond the scope of the community-based program, or those who demonstrate little regard for their actions or interest in receiving help.

Table 3. Specialized Assessment Instruments
▪ *Multiphasic Sex Inventory*[54] ▪ *Adolescent Cognitions Scale*[55] ▪ *Adolescent Sexual Interest Card Sort*[56]
Inventories Appropriate for Children with Sexual Behavior Problems ▪ *Child Sexual Behavior Inventory*[57]
General Assessment Instruments ▪ *MMPI-A*[58] ▪ *Child Behavior Checklist*[59] ▪ *Family Environment Scale*[60] ▪ *Child and Adolescent Functional Assessment Scale*[61]
Adjunctive Assessment Tools[62] ▪ *Plethysmograph* ▪ *Polygraph*

Clinical Assessment

Professional evaluation of youth and their appropriateness for placement should be conducted post-adjudication and prior to court sentencing. Clinical assessments should be comprehensive and may include careful record review, clinical interviewing, screening for co-occurring psychiatric disorders, and the administration of both specialized psychometric instruments designed to assess sexual attitudes and interests, as well as those related to more global personality adjustment and functioning.

Assessment of the Youth's Home

Assessments of the juvenile's appropriateness for community-based programming should include a thorough review of his or her living arrangements, as well as a determination as to whether his or her parents are capable of supervising the youth. Proper assessment requires evaluation of whether the living environment affords the level of structure and supervision necessary for the youth while providing for the safety of others in the home and the community. Special consideration must be given to the needs and concerns of individuals living in the home who may have been victimized by the youth (e.g., younger siblings). It is essential that other children are protected from potential harm, both physical and psychological. It is often necessary to place a juvenile who sexually offends against family members temporarily outside of the home. These youth should not be returned home until sufficient clinical progress is attained, and issues of safety and psychological comfort of family members are resolved. For an adjudicated youth, this decision is typically made by the presiding judge with input from the parole/probation officer and social services worker, the youth's treatment provider, the provider of services to family victim(s), and the youth's family.

CLINICAL PROGRAMMING

Clinical programming for sexually abusive youth typically includes a combination of individual, group, and family therapies. In addition, many programs offer supportive educational groups to families of these youth. Juveniles who display more extensive psychiatric or behavioral problems, such as substance abuse, may require additional treatment, including drug and alcohol rehabilitation and psychiatric care. All therapies provided to sexually abusive youth should be carefully coordinated within the treatment agency and with external agencies providing case management and oversight. Treatment programs need to be individually tailored through a thorough assessment of the youth, family, and environment.

Providers have established the following as essential components of the treatment process:

- Gaining control of behavior.
- Teaching the impulse control and coping skills needed to successfully manage sexual and aggressive impulses.
- Teaching assertiveness skills and conflict resolution skills to manage anger and resolve interpersonal disputes.

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[54] Nichols, H.R. & Molinder, M.A. (1984). *Multiphasic Sex Inventory Manual*. (437 Bowes Drive, Tacoma, WA 98466).
[55] Hunter, J.A., Becker, J.V., Kaplan, M., & Goodwin, D.W. (1991). *The Reliability and Discriminative Utility of the Adolescent Cognition Scale for Juvenile Sexual Offenses*. Annals of Sex Research (4), pp. 281-286.
[56] Ibid.
[57] Friedrich, W.N., Grambsch, P., Damon, L., & Hewitt, S. (1985). *Child Sexual Behavior Inventory: Normative and Clinical Comparisons*. Psychological Assessment (4), pp. 303-311.
[58] Archer, R.P. (1997). *MMPI-A: Assessing Adolescent Psychopathology (2nd Edition)*. Mahwah, NJ: Lawrence Erlbaum Associates.
[59] Achenbach, T.M., McConaughy, S.H., & Howell, C.T. (1987). *Child and Adolescent Behavioral and Emotional Problems: Implications of Cross-Informant Correlations for Situation Specificity*. Psychological Bulletin (101), pp. 213-232.
[60] Moos, R.H. & Moos, B.S. (1986). *Family Environment Scale Manual (2nd Edition)*. Palo Alto, CA: Consulting Psychologists Press.
[61] Hodges, K., McKnew, D., Cytryn, L., Stern, L., & Klien, J. (1982). *The Child Assessment Schedule (CAS) Diagnostic Interview: A Report on Reliability and Validity*. Journal of the American Academy of Child Psychiatry (21), pp. 468-473.
[62] There is little research on these tools to determine whether they are effective on juvenile populations.

- Enhancing social skills to promote greater self-confidence and social competency.
- Programming designed to enhance empathy and promote a greater appreciation for the negative impact of sexual abuse on victims and their families.
- Provisions for relapse prevention. This includes teaching youths to understand the cycle of thoughts, feelings, and events that are antecedent to the sexual acting-out, identify environmental circumstances and thinking patterns that should be avoided because of increased risk of reoffending, and identify and practice coping and self-control skills necessary for successful behavior management.
- Establishing positive self-esteem and pride in one's cultural heritage.
- Teaching and clarifying values related to respect for self and others, and a commitment to stop interpersonal violence. The most effective programs promote a sense of healthy identity, mutual respect in male-female relationships, and a respect for cultural diversity.
- Providing sex education to give an understanding of healthy sexual behavior and to correct distorted or erroneous beliefs about sexual behavior.

The planning and implementation of treatment services ideally reflect the collaborative involvement of the youth, family, and all agencies involved in the youth's care as well as those agencies serving victims of these youth. Often, this is accomplished by forming an advisory board to oversee the operation of the program and serve as a mediator between the program and the community. These boards typically consist of representatives from public institutions serving youths and families, including the local juvenile court, the department of social services, the prosecutor's office, the public defender's office, victim advocacy services, and parents of youthful perpetrators. The advisory board helps to ensure that the treatment program is serving the needs of its clients while meeting community safety standards.

Controversial Areas of Practice

The following areas of practice have generated controversy, and therefore pose special ethical and legal risks for practitioners assessing and treating sexually abusive youth.[63]

Involuntary Treatment

Treatment of juveniles who sexually offend is usually court ordered or mandatorily provided in correctional settings. Historically, juvenile courts have prescribed mental health care for youths with an emphasis on rehabilitation. In contrast, adult courts have typically ordered involuntary treatment on the grounds that the youth represents an imminent danger to public safety.

Given the shift of juvenile courts to a more adult-like criminal justice model, and the increasing frequency with which juveniles are being adjudicated and tried as adults, the issue of involuntary treatment may need to be reexamined. Judicial decisions are no longer made with a consistent emphasis on rehabilitation rather than punishment as a means of ensuring public safety. However, many sexually abusive youth may not meet the legal criteria for involuntary treatment based upon imminence of danger criteria.

Pre-Adjudication Evaluations

A number of sexually abusive youth are referred for evaluation prior to the initiation or completion of the adjudication process. Often, these referrals are made by the court, or another public agency, in an attempt to determine the most appropriate disposition for alleged sexual abusers.

Pre-adjudication assessments raise a number of ethical and legal issues. Youths facing prosecution are placed in the position of being asked to reveal information that may be used against them in court. Evaluations present another set of problems associated with the validity of available assessment instrumentation to determine innocence or guilt. There is no scientific basis for assuming that any currently available psychometric or psychophysiological measure of personality or sexual interest is valid for that purpose.[64]

Risk Assessment

The courts frequently give clinicians the responsibility of determining the youth's risk of recidivism. These assessments are used to make dispositional decisions and, as a result of legislative mandates, have potential relevance in determining which juveniles should be placed on state registries, as well as whether information about certain sexually abusive youth should be released to the public.

Unfortunately, risk assessment, especially risk of violence, remains an inexact science.[65] Although a number of risk assessment instruments are emerging as promising in the assessment of risk of adult sex offenders, to date none of these have been validated on a juvenile population. At this time, clinicians working with sexually abusive youth rely on experience, existing research on delinquency and pro-social functioning of youth, and retrospective and actuarial information on

[63] See Hunter & Lexier (1998), for a more complete discussion of these issues.

[64] Murphy, W.D. & Peters, J.M. (1992). *Profiling Child Sexual Abusers: Psychological Considerations*. Criminal Justice and Behavior (19), pp. 24-27.

[65] Borum, R. (1996). *Improving the Clinical Practice of Violence Risk Assessment: Technology, Guidelines, and Training*. American Psychologists (51), pp. 945-956. Monahan, J. & Steadman, H.J. (1996). *Violent Storms and Violent People: How Meteorology can Inform Risk Communication in Mental Health Law*. American Psychologists (51), pp. 931-938.

adults who reoffend in making their evaluations of the risk posed by a youth.

A recent study has presented encouraging findings on an actuarial scale for assessing risk among adolescent sexual abusers.[66] In this study, the Juvenile Sex Offender Assessment Protocol (J-SOAP) was used to assess risk on 96 youth receiving treatment in an institutional setting. Results from a 12-month follow-up period suggest that the instrument is reliable, internally consistent and appears to possess concurrent and predictive validity. The J-SOAP is currently being used in a variety of locations and continues to be the subject of empirical scrutiny.

Phallometric Assessment

Phallometry is a diagnostic method to assess sexual arousal by measuring blood flow (tumescence) to the penis during the presentation of potentially erotic stimuli in the laboratory. The plethysmograph is a tool commonly used in phallometric assessment. Use of the plethysmograph with juveniles is an issue of some controversy.[67] Research suggests that issues of client age and denial compromise the validity of plethysmographic assessment of juveniles. Younger clients appear to produce less reliable patterns of responding, and those who deny their offenses tend to produce suppressed, and therefore non-interpretable, patterns of arousal.[68] Most practitioners agree that phallometric assessment should not be used on youth under the age of 14. Phallometric assessments of sexual arousal patterns are most appropriate for older adolescent males who report deviant sexual interest, and/or those juveniles with more extensive histories of sexual offending. Under these circumstances, such assessments may be useful for identifying youths with emergent paraphilic (sexual deviation) disorders as well as helping youth to become more aware of patterns and strengthen non-problematic interests.[69]

Polygraph

The purpose of a polygraph examination is to verify a perpetrator's completeness regarding offense history and compliance with therapeutic directives and terms of supervision.[70] The polygraph is used more often with adult offenders than with juveniles. To date, there is little research on the polygraph's reliability and validity in the evaluation of sexually abusive youth. Research suggests that results potentially can be affected by a number of influences, including the client's physical and emotional status, the client's age and intelligence, and the examiner's level of training and competency.[71] Most practitioners using the polygraph indicate that the age threshold for use with juveniles is approximately 14 years old.

Polygraph Legislation in Texas

In Texas, law requires use of the polygraph on certain sexually abusive youth. In 1997, legislation was enacted that prescribed release conditions, including counseling and treatment for adolescents convicted of certain sex offenses. Under this law, youth can be required, as a condition of release from the Texas Youth Commission, to attend psychological counseling sessions and to submit to polygraph examinations in order to evaluate treatment progress (Texas Human Resources Code, Title 3, Ch. 61, Sub. A, Sec. 61.0813).

Arousal Conditioning and Psychopharmacologic Therapies

Therapeutic techniques designed to change patterns of sexual arousal remain controversial. Studies examining the effectiveness of techniques such as arousal conditioning and drug therapies are inconsistent.[72] Concerns about the appropriateness of techniques exposing juveniles to physically or emotionally painful stimuli or involving masturbation render arousal conditioning questionable.[73] While several reports about the use of drug therapy have appeared over the past few years, little information exists about the safety and effectiveness of these drugs when used on juveniles.[74] In particular, anti-androgens and hormonal agents have typically not been used with individuals under the age of 18 because of their potential suppression of growth, and the other yet unknown long term risk that they may present. Selective Serotonin Reuptake Inhibitors (SSRIs)[75] are helpful in reducing the frequency and/or intensity of sexual arousal and thoughts. SSRIs are a class of antidepressant drugs known to cause a decrease in sexual arousal. Further research is examining the effectiveness of such drugs in reducing deviant sexual behavior.

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[66] Prentky, R.A., Harris, B., Frizzell, K., & Righthand, S. (in press). *An Actuarial Procedure for Assessing Risk with Juvenile Sex Offenders.* Sexual Abuse: A Journal of Research and Treatment.

[67] National Task Force on Juvenile Sexual Offending, 1993.

[68] Becker, J.V., Kaplan, M.S., & Tenke, C.E. (1992). *The Relationship of Abuse History, Denial and Erectile Response: Profiles of Adolescent Sexual Perpetrators*. Behavior Therapy (23), pp. 87-97. Kaemingk, K.L., Koselka, M., Becker, J.V., & Kaplan, M.S. (1995). *Age and Adolescent Sexual Offender Arousal*. Sexual Abuse: A Journal of Research and Treatment (7), pp. 249-257.

[69] Guidelines for appropriate clinical use of the plethysmograph can be found in the report of the National Task Force on Juvenile Sexual Offending (1993).

[70] Edson, C. (1991). *Sex Offender Treatment*. Medford, OR: Department of Corrections. Emerick, R. & Dutton, W. (1993). *The Effect of Polygraphy on the Self-Report of Adolescent Sex Offenders: Implications for Risk Assessment*. Annals of Sex Research (6), pp. 83-103.

[71] Blasingame, G.D. (1998). *Suggested Clinical Use of Polygraphy in Community-Based Sexual Offender Treatment Programs*. Sexual Abuse: A Journal of Research and Treatment (10), pp. 37-45.

[72] Hunter & Goodwin, 1992.

[73] National Task Force on Juvenile Sexual Offending, 1993.

[74] These medications include anti-depressant and anti-obsessional agents, as well as anti-androgen and hormonal agents.

[75] SSRIs include fluoxetine (Prozac), fluvoxamine, paroxetine and sertraline.

Legal and Clinical Concerns

Subjecting juveniles to stricter penalties for sex offenses poses special legal and clinical concerns. Legal issues can arise in the courtroom when determining if these youth have the capacity to understand their cases, to properly consult their attorneys, or to make sound decisions regarding their defense.[76] Clinical concerns arise when clinicians place demands on their clients to divulge information that may incur additional restrictions or legal sanctions. Proper warning regarding the limits of confidentiality is necessary and may include referral to parents or attorneys prior to encouraging such disclosures. In many jurisdictions, clinicians develop policies with district attorneys to clarify the consequences of new disclosures in the course of treatment.[77] Without these precautions, the reporting of such information may interfere with the development of the therapist/client relationship, an essential component of the treatment process, and increase clinician vulnerability to civil suit.[78] As with adult offenders, these policies must address harm done to victims identified through new disclosures and ways to offer assistance to these victims.

Areas for Future Research

Continued research is needed in each of the previously described areas. Research on etiology is especially important to the development of prevention programming for high-risk youths. Presently, the National Center for Child Abuse and Neglect is funding two demonstration projects to evaluate treatment outcomes for pre-pubescent children with sexual behavior problems. Studies on effective supervision strategies for sexually abusive youth are clearly needed. Treatment outcome studies that examine both individual and program characteristics associated with positive treatment outcomes are also needed. Research should focus on early identification of youths demonstrating patterns of escalating aggression and violence. The U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention's currently funded research on the creation of a typology of juvenile sexual offending behavior will help mental health and criminal justice professionals better understand the major subtypes of sexually abusive youth and the most effective intervention strategies for these groups.

[76] Grisso, T. (1997). *The Competence of Adolescents as Trial Defendants*. Psychology, Public Policy, and Law (3), pp. 3-32.
[77] National Task Force on Juvenile Sexual Offending, 1993.
[78] Hunter & Lexier, 1998.

Recommendations for Practice

The following suggestions may be used as guidelines for the ethical and effective treatment of juveniles who abuse.[79]

Clinical Assessments: When possible, clinicians should conduct evaluations after adjudication and before sentencing. Clinical assessments should help determine required level of care, identification of treatment goals and objectives, and estimated risk of reoffending. Clinical assessment should not be directed at determination of innocence or guilt.

Clinicians' Roles: Clinicians should carefully explain their role, as well as the limits of professional confidentiality, to juvenile clients and their family prior to conducting a clinical interview or administering assessment tests. Furthermore, it is strongly recommended that consent forms, releases, and/or waivers addressing these issues be signed by clients and their families. It is also prudent to review the above issues with clients' defense attorneys and/or guardian ad litems representing the youths.

Consent Forms: Clinicians should consider developing additional consent forms to cover the use of more controversial assessment or treatment procedures (e.g. phallometric assessment, aversive conditioning, and "off-label" use of medications). These consent forms should be specific to the procedure and clearly identify any potential risks associated with it. Clients should understand that these procedures are voluntary and that they are free to decline them.

Phallometric and Polygraph Assessments: Phallometric and polygraph assessments should be administered judiciously. Phallometric assessment is best limited to males 14 years of age or older with extensive histories of sexual offending, and/or those who self-report deviant sexual arousal and interest patterns. This procedure should only be used with the full, informed consent of the youth, their parent(s) or guardian, and preferably the referral agency. Furthermore, it should only be used with those who admit to their offenses and should generally be conducted with auditory stimuli specifically designed for sexually abusive youth.

Risk Assessment: Clinicians should exercise caution in rendering judgments of risk that individual juveniles represent for further sexual offending. This is especially true when these judgments will figure prominently in legal dispositions. Such assessments should state that they reflect the best available predictive information on these issues, but that empirical support for risk models is tentative at present.

[79] Ibid.

Treatment Plans: Clinicians should demonstrate sensitivity to developmental issues in assessing juveniles with sexual behavior problems and formulating intervention plans. Treatment plans should be comprehensive, reflecting a holistic understanding of youths, family systems, and sociocultural environment in which they live.

Supervision Strategies: Sexually abusive youth have always been in the community, and have been increasingly identified and supervised by probation for many years. Only recently has the field moved toward the development of specialized strategies to manage this unique population. To be sure, this is an emerging area and one where much is yet to be learned. However, many of the approaches commonly used with adult sex offenders (e.g., the use of specialized supervision staff, sex offender specific treatment providers, and the polygraph) are being adopted by juvenile supervision agencies around the country. Models of a team approach to sex offender management—teaming supervision agency staff with therapists, school personnel, victim advocates and others to work closely with the offender, his/her family, and victim(s)—are emerging as among the most promising approaches to sex offender supervision.

Conclusion

Adolescents account for a significant percentage of the sexual assaults against children and women in our society. The onset of sexual behavior problems in juveniles appears to be linked to a number of factors, including child maltreatment and exposure to violence. Emerging research suggests that, as in the case of adult sex offenders, a meaningful distinction can be made between juveniles who target peers or adults and those who offend against children. The former group appears generally to be more antisocial and violent, although considerable variation exists within each population. Although available research does not suggest that the majority of sexually abusive youth are destined to become adult sex offenders, legal and mental health intervention can have significant impacts on deterring further sexual offending. Currently, the most effective intervention consists of a combination of legal sanctions and specialized clinical programming.

References

The National Adolescent Perpetration Network, contact: Gail Ryan, M.A., Kempe Children's Center, 1825 Marion Street, Denver, CO 80218, phone (303) 864-5252, fax (303) 864-5179, e-mail: Kempe@KempeCenter.org.

The Association for the Treatment of Sexual Abusers (ATSA), Connie Isaac, Executive Director, 10700 S.W. Beaverton-Hillsdale Hwy., Suite 26, Beaverton, OR 97005-3035, phone (503) 643-1023, fax (503) 643-5084, e-mail: connie@atsa.com.

Jefferson County, Colorado; contact: Leah Wicks, Supervisor, Juvenile Sex Offender Program, First Judicial District Probation Department, 100 Jefferson County Parkway, Suite 2070, Golden, CO 80401.

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Contact Information

Center for Sex Offender Management
8403 Colesville Road, Suite 720
Silver Spring, MD 20910
Phone: (301) 589-9383
Fax: (301) 589-3505
askcsom@csom.org
www.csom.org

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