



SEXUAL OFFENDING

OVERVIEW

Juvenile sexual offenders can be defined as youth who commit any sexual interaction with persons of any age against their will, consent, or in an aggressive, exploitative, or threatening manner. While the majority of juvenile sexual offenders are between puberty and the age of legal majority, a small number of juvenile offenders are younger than 12 years of age. Sexually abusive behaviors can vary from non-contact offenses to contact offenses. A contact offense requires unwanted physical contact with a victim. With a non-contact offense, the perpetrator has no physical contact with the victim (e.g., Internet crimes). Juvenile sexual offenders' behaviors have the potential to cause significant harm to others and also have significant legal ramifications. It is important to note that it is not until the youth has been found guilty or adjudicated in a court of law that the term "juvenile sexual offender" is technically accurate. However, the term "juvenile sexual offender" will be utilized in this section since much of the research on youth who engage in sexually abusive behavior utilizes this term.

Juvenile sexual offenders are fundamentally different from adults in their cognitive capabilities and their ability to regulate emotions and control behavior. Juveniles also have less capacity than adults in weighing the consequences of their actions. Research demonstrates the regions of the brain associated with foresight and planning continue to develop well beyond adolescence. These factors must be acknowledged in the assessment and treatment of juvenile sexual offenders.

Research has shown that there are two types of juvenile sexual offenders: those who target children, and those who offend against their peers or against adults. Moreover, there are also differences in motivation. Some offenders have histories of violating the rights of others, some are sexually curious, and some have serious mental health issues or poor impulse control.

A significant proportion of juvenile sexual offenders may present with a diverse range of disordered behaviors, such as aggressive behavior, bullying, vandalism, firesetting, cruelty to animals, shoplifting, and drug/alcohol abuse. However, juvenile sexual offenders differ from their adult counterparts in that juveniles typically do not

KEY POINTS

- Sexual abusive behaviors include contact offenses (unwanted or forced sexual contact) and non-contact offenses (e.g., internet crimes).
- 90 percent of juvenile sexual offenders are male, and 80 percent have one or more mental health disorders.
- Previous sexual victimization is correlated with later sexually abusive behavior.
- Multisystemic therapy and cognitive behavioral therapy that specifically targets sexual offending is the preferred treatment.

present with the same types of sexual deviancy and psychopathic tendencies that may be observed among adult offenders.

In general, 90 percent of all juvenile sexual offenders are male. Of that number, a significant portion of those ages 12 to 14 years target four- to seven-year-old boys. By contrast, older offenders tend to abuse older female victims, peaking with 15- to 17-year-old boys targeting 13- to 15-year-old girls. This suggests that teen offenders targeting boys seek younger, sexually immature boys rather than peers, and older teen offenders target sexually mature females.

Figure 1 outlines the characteristics of sexually abusive juveniles.

Figure 1
Characteristics of Sexually Abusive Juveniles

- Perpetrators are typically adolescents, age 12 to 17.
- Perpetrators are predominantly male.
- Perpetrators have difficulties with impulse control and judgment.
- Up to 80 percent of perpetrators have a diagnosable psychiatric disorder.
- Between 30 to 60 percent of perpetrators exhibit learning disabilities and academic dysfunction.

Preliminary research indicates that juvenile sexual offenders share some characteristics other than sexual offending, including:

- High rates of learning disabilities and academic dysfunction
- Attention-deficit/hyperactivity disorder
- The presence of other behavioral problems and conduct disorder
- Difficulties with impulse control and judgment

Ignoring comorbid mental health disorders may compromise the efficacy of structured sex offender treatment. Treatment for the comorbid mental health disorder may sometimes be provided simultaneously with other forms of sexual offender treatment. However, if the juvenile offender is psychotic, manic, or severely depressed, treatment in an inpatient setting may be necessary.

CAUSES AND RISK FACTORS

The causes of juvenile sexual offending are not well understood. However, sexual and physical abuse, child neglect, and exposure to family/domestic violence are all factors associated with juvenile sexual offending. There is strong evidence that indicates that sexual victimization in childhood plays a role in the development of sexually abusive behavior in adolescents. For this reason, clinicians should consider incorporating principles of trauma-informed care into evidence-based sex offender treatment models. Early trauma paves the way for maladaptive coping and interpersonal deficits, which can lead to abusive behavior.

Female sexual offending has been under-reported and under-represented in sexual offender literature, but preliminary research has revealed that many of these females had very disruptive and tumultuous childhoods,

with high levels of trauma and exposure to dysfunction with post-traumatic stress disorder (PTSD) being especially prevalent. Compared to those of juvenile males, the histories of females in these studies reflected even more extensive and pervasive childhood maltreatment by both females and males. They were also victimized at younger ages and were more likely to have had multiple perpetrators. In prepubescent female sexual offenders, rates of sexual victimization tends to be extraordinarily high, with rates greater than 90 percent.

TREATMENTS

Once a juvenile sexual offender has been identified, careful assessment is critical so that his or her needs can be matched to the correct type and level of treatment. Ideally, the assessment will indicate the level of danger that the juvenile presents to the community, the severity of psychiatric and psychosexual problems, and the juvenile's amenability to treatment. All available participants should be included in the assessment process, including the youth, his or her parents or guardians, and all other professionals involved, such as teachers, case workers, social workers, and mental health treatment providers. It should be expected that the youth and his or her family may be at various psychological stages, ranging from complete denial to full acknowledgment of the sexual offense(s). For this reason, it is important that full acknowledgment of offending behaviors and their impact on others is a primary goal of treatment. Decisions about whether an adolescent sexual offender should remain in the same home as the victim of his or her offense should be made carefully on a case-by-case basis. The decision may involve input from a variety of professionals (e.g., child protection workers, therapists, etc.). It is essential that the community and other children be protected from potential harm, both physical and psychological.

Research has demonstrated that the overall prognosis for children with sexual behavior problems is good and that sexually abusive juveniles benefit from treatment. Although there are no evidence-based treatments at this time, promising sexual offender treatment programs often combine an intensive, multi-modal approach with early intervention. Comprehensive treatment may focus on taking responsibility for one's sexual behavior, developing victim empathy, and developing skills to prevent future offending. A summary of promising treatments is provided in Table 1.

When seeking professional services for sexual offenders, it is prudent to ensure that the qualifications of the service provider indicate expertise in the treatment of sexual offenders. One way to ensure such expertise is to select a professional with this certification (CSOTP). Qualifications include a minimum of a master's or doctoral degree in a selected field or a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) degree from an institution that is approved by an accrediting agency recognized by the Virginia Board of Medicine. Qualifications also include 50 hours of sex offender treatment-specific training; 2,000 hours of post-degree clinical experience, 200 of which must be face-to-face treatment/assessment of sexual offenders; and 100 hours of face-to-face supervision within the 2,000 hours experience with a minimum of six hours per month. A minimum of 50 hours shall be in individual, face-to-face supervision.

Table 1
Summary of Treatments for Sexually Offending Youth

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Multisystemic therapy for problem sexual behaviors (MST-PSB)	An intensive family- and community-based treatment that addresses the multiple factors of serious antisocial behavior in juvenile sexual abusers.
Cognitive behavioral therapy (CBT) Children with problematic sexual behavior CBT (PBS-CBT)	Treatment modalities that provide cognitive-behavioral, psychoeducational, and supportive services.
Not Adequately Tested	
Medication	There is no research validation for the use of medication targeting sexually deviant behavior in youth and only limited methodologically sound research to guide in the treatment of adults.

Multisystemic Therapy for Problem Sexual Behaviors (MST-PSB)

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

Like standard multisystemic therapy, MST-PSB specifies a model of service delivery rather than a manualized treatment with sequential session content. It utilizes several standard interventions, including individual (e.g., social skills training, cognitive restructuring of thoughts about offending), family (e.g., caregiver skills training, communication skills training, marital therapy), peer (e.g., developing prosocial friendships, discouraging affiliation with delinquent and drug-using peers), and school levels (e.g., establishing improved communication between caregivers and school personnel, promoting academic achievement). The overarching goal of MST-PSB is to empower caregivers (and other important adult figures) with the skills and resources needed to address the youth’s problem sexual behaviors and any other behavior problems. Services are delivered to the youth and their caregivers in home, school, and neighborhood settings at times convenient to the family (including evenings and weekends), with intensity of treatment matched to clinical need. Client contact hours are typically higher in the initial weeks of treatment (three to four times per week if indicated) and taper off during a relatively brief course of treatment (five to seven months on average).

Cognitive Behavioral Therapy (CBT)

CBT is the most common treatment for juvenile sexual offenders. One form of CBT that has positive results is Children with Problematic Sexual Behavior–Cognitive Behavioral Therapy (PSB-CBT). The primary goal of PSB-CBT is to reduce and eliminate sexual behavior problems among school-age children. The program provides cognitive-behavioral, psychoeducational, and supportive services to children referred to the program for sexual behavior problems and their families. Intermediate goals are to increase awareness of sexual behavior rules and expectations, strengthen parent-management skills, improve parent-child communications and interactions, improve children’s self-management skills related to coping and self-control, improve children’s social skills, and decrease children’s internalizing and externalizing behaviors. Interventions are offered in community-based and/or residential settings and are primarily delivered in individual and/or group therapy sessions, although family sessions are frequently incorporated as well.

Female Juvenile Sexual Offenders Treatment

Because assessment and treatment tools have only been validated on male offenders and are primarily tested on adult subjects, it is unclear how effective they are with juvenile female offenders. Preliminary research suggests that traditional psychological evaluation (e.g., intellectual and personality assessment) may be of more value with female juvenile offenders, and treatment approaches should address the early and repetitive developmental traumas experienced by these offenders. Furthermore, female juvenile sexual offenders may benefit from a focus on the unique considerations of gender issues, including sexual and physical development, intimacy and social skills, self-image, self-esteem, impulsivity, comorbid symptoms of PTSD, and the common societal expectation of females as caregivers/nurturers.

VIRGINIA’S SEXUAL OFFENDER TREATMENT PROGRAM

Currently, the Virginia Department of Juvenile Justice (VDJJ) provides cognitive-behavioral sexual offender evaluation and treatment services. These are provided in specialized treatment units and in the general population.

Inpatient and moderate treatment is delivered in a group format in self-contained units for high-risk juveniles, with inpatient treatment more intensive than moderate treatment. Prescriptive treatment is delivered individually as needed. Juveniles in sex offender treatment units receive intensive treatment by a multidisciplinary treatment team that includes a community coordinator, counselor, and specially trained therapists. Specialized sex offender treatment units offer an array of services, including individual, group, and family therapy. Each juvenile receives an individualized treatment plan that addresses programmatic goals, competencies, and core treatment activities. Successful completion of sex offender treatment may require six to 36 months depending on treatment needs, behavioral stability, and motivation of the juvenile. The median treatment time is approximately 18 months.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)

<https://www.aacap.org/>

Association for Behavior and Cognitive Therapies (ABCT)

<http://www.abct.org>

Association for the Treatment of Sexual Abusers

<http://www.atsa.com/>

Center for Sex Offender Management (CSOM)

<http://www.csom.org/>

Child Welfare Information Gateway

Juvenile Sex Offenders

<https://www.childwelfare.gov/topics/can/perpetrators/perp-sexabuse/juvenile/>

Juvenile Forensic Evaluation Resource Center

Sex Offender Forensic Programs

<http://www.ilppp.virginia.edu/OREM/SexOffenderPrograms>

National Center on Sexual Behavior of Youth

<http://www.ncsby.org/>

National Council of Juvenile and Family Court Judges

Juvenile Sex Offenders

<https://www.ncjfcj.org/our-work/juvenile-sex-offenders>

Office of Juvenile Justice and Delinquency Prevention (OJJDP)

Juvenile Sex Offender Research Bibliography

<https://www.ojjdp.gov/juvsexoff/sexbibtopic.html>

Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART)

<https://ojp.gov/smart/>

Society of Clinical Child and Adolescent Psychology

<https://sccap53.org/>

Virginia Department of Juvenile Justice (VDJJ)

<http://www.djj.virginia.gov/>

***The Collection of Evidence-based Practices for Children and Adolescents with
Mental Health Treatment Needs, 7th Edition***
Virginia Commission on Youth, 2019

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