

# S EXUAL OFFENDING

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## **Introduction**

Juvenile sexual offenders are 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 (Finklehor, Ormrod, & Chaffin, 2009; Scavo & Buchanan, as cited by Ryan, Hunter, & Murrie, 2014). 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 (Finklehor, Ormrod, & Chaffin). 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) (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2001). Juvenile sexual offenders' behaviors have the potential to cause significant harm to others and also have significant legal ramifications (O'Reilly & Dowling, 2008). 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 offending is a serious problem that has increasingly become a focus of attention and concern (Finklehor, Ormrod, & Chaffin, 2009). A 2009 research brief from the U.S. Department of Justice notes that juveniles account for more than one-third (35.6 percent) of those who have committed sex offenses against minors and comprise more than one-quarter (25.8 percent) of all sexual offenders (Fonagy et al., 2015; Finkelhor, Ormrod, & Chaffin). Research also suggests that the proportion of juvenile offenders increases as the age of the victim decreases (Fonagy et al.). Approximately half of all adult sexual offenders began their criminal offenses during adolescence (Chu & Thomas, 2010; Saleh & Vincent, 2004). In Virginia during Fiscal Year 2016, 14 percent of the admissions to the Virginia Department of Juvenile Justice (VDJJ) were for sexual abuse offenses, with the sexual abuse offense being the most serious committing offense (VDJJ, 2016).

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 (U.S. Department of Justice Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking [SMART], 2014). These factors must be acknowledged in the assessment and treatment of juvenile sexual offenders.

### **Etiology and Characteristics of Juvenile Sexual Offenders**

The research on etiological factors for sexual offending includes studies that focus on single factors as well those that focus on multiple factors. There is consensus that etiological factors typically vary in the development and onset of sexual offending and nonsexual delinquency adolescence (U.S. Department of Justice, Office of SMART, 2014). These factors will be highlighted in the paragraphs that follow.

Sexual and physical abuse, child neglect, and exposure to family/domestic violence are all factors associated with juvenile sexual offending (Finklehor, Ormrod, & Chaffin, 2009; Center for Sex Offender Management, 1999). There is strong evidence that indicates that sexual victimization in childhood plays a role in the development of sexually abusive behavior in adolescents (Jespersion, Lalumiere, & Seto, 2009). Grabell and Knight (2009) examined child sexual abuse patterns and sensitive periods in the lives of juveniles who had committed sexual offenses. They found that children between ages three and seven are at an age when sexual abuse can do the most damage and place youth at higher risk for engaging in sexually abusive behavior later in life. This study found that both the ages of the victims and the length of the sexual abuse are significant factors that contribute to attitudes and behaviors in juveniles who commit sexual offenses.

Research has also shown that there are two types of juvenile sexual offenders: those who target children, and those who offend against their peers or against adults (Hunter, 2000). 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 (Finklehor, Ormrod, & Chaffin, 2009).

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 (Finklehor, Ormrod, & Chaffin, 2009). By contrast, older offenders tend to abuse older female victims, peaking with 15 to 17 year olds 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 (Finklehor, Ormrod, & Chaffin). 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.

Sources: Center for Sex Offender Management, 1999; Hunter, 2000; Finklehor, Ormrod, & Chaffin, 2009.

Research has provided several promising leads to understanding the juvenile sexual offender. 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. Furthermore, although rates of sexual re-offending are generally low-to-moderate for juvenile sexual offenders overall (8 to 15 percent), evidence suggests that youth who have offended sexually and who are highly antisocial have an extremely high risk of re-offending when criminal profiles include non-sexual charges (46 to 54 percent) (Lobanov-Rostovsky, 2015; O'Reilly & Carr, 2006; Worling & Langstrom, 2006).

Juvenile sexual offenders differ from their adult counterparts in that juveniles typically do not present with the same types of sexual deviancy and psychopathic tendencies that may be observed among adult offenders (Saunders, Berliner, & Hanson, 2001). However, there is evidence that juvenile sexual offenders who evade detection and/or treatment may be at higher risk of continued re-offending (Trivits & Reppucci, 2002).

### ***Female Juvenile Sexual Offenders***

There are few studies that address female juvenile sexual offenders. Due to the difficulty in finding adequate samples of female participants, female sexual offending has been under-reported and under-represented in sexual offender literature (National Center on Sexual Behavior of Youth [NCSBY], 2004).

Although these studies have limitations, they have been pertinent in identifying implications for treating female juvenile sexual offenders (National Center on Sexual Behavior of Youth [NCSBY], 2004). Preliminary research has revealed that 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 (Hunter, Becker, & Lexier, 1997). Compared to those of juvenile males, the histories of females in these studies reflected even more extensive and pervasive childhood maltreatment because many of these females were exposed to interpersonal aggression by both females and males (Mathews, Hunter, & Vuz; NCSBY). Physical abuse is present in 20 percent of studied cases and sexual abuse is present in 50 percent of studied cases (Mathews, Hunter, & Vuz; NCSBY). Moreover, these females' histories revealed that they were victimized at younger ages and were more likely to have had multiple perpetrators (Mathews, Hunter, & Vuz; NCSBY). In samples of prepubescent female sexual offenders, rates of sexual victimization tend to be extraordinarily high, with rates greater than 90 percent (Hunter, Becker, & Lexier, 2006). High levels of impulsive delinquent behaviors, including substance abuse and other high-risk behaviors, were also observed (Mathews, Hunter, & Vuz).

Studies are being conducted to ascertain effective assessment and treatment measures for female juvenile sexual offenders. Tools used to assess female juvenile sexual offenders are lacking since they have been validated only on male offenders and have not yet been empirically validated with a female population (Center for Sex Offender Management [CSOM], 2007). Furthermore, most treatments are primarily tested on adult subjects and have less external validity with the youth population (Ryan, Hunter, & Murrie, 2014). Traditional psychological evaluation (e.g., intellectual and personality assessment) may be of more value with female juveniles until future tools are empirically validated with this population (Hunter, Becker, & Lexier, 2006). Preliminary results indicate that treatment approaches should be used to 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 (Roe-Sepowitz & Krysik, 2008).

## **Comorbidity**

There have been studies conducted to ascertain the co-occurrence of mental health disorders in juvenile sexual offenders; however, many of these studies are limited (Ryan, Hunter, & Murrie, 2014; Boonmann et al., 2016a). The studies conducted to date have found that juvenile sexual offenders may share some characteristics other than sexual offending, including:

- High rates of learning disabilities and academic dysfunction;
- Attention-deficit/hyperactivity disorder (ADHD);
- The presence of other behavioral problems and conduct disorder; and
- Difficulties with impulse control and judgment (Saleh & Vincent, 2004).

One study found that three quarters of juveniles who sexually offended met criteria for at least one mental health disorder (‘t Hart-Kerkhoffs et al., 2015). Juvenile sexual offenders with prepubescent child victims showed higher rates of internalizing and affective disorders (e.g., depression, bipolar disorder, and anxiety disorder) with 63 percent having one of these diagnoses. Of juvenile sexual offenders with prepubescent child victims, 58 percent had an ADHD diagnosis, 53 percent had a disruptive behavior disorder diagnosis (e.g., conduct disorder and oppositional defiant disorder), and 21 percent had a substance use disorder (‘t Hart-Kerkhoffs et al.).

A recent study comparing mental health concerns of young male offenders with and without sex offenses found that those with a history of sexual offending were more likely to report internalizing mental health problems such as suicidal ideation and thought disturbance. Those with externalizing mental health problems were more likely to have anger-irritability problems (Boonmann et al., 2016b). This study also noted a relationship between these symptoms and childhood abuse or neglect, especially sexual abuse, when compared to youth with similar symptoms who did not have histories of sexual offending. This study concluded that because internalizing mental health disorders are harder to detect than externalizing mental health problems, it is of great importance to assess juvenile sexual offenders for both internalizing and externalizing mental health disorders. Because there is evidence that the relationship between sexual abuse and sexual offending behavior could be caused indirectly through mental health disorders, one aspect of sexual violence risk management among juveniles who have experienced sexual abuse could include treatment with a focus on healthy development and behaviors (Boonmann et al.).

Adolescent female sexual offenders also report high levels of childhood physical abuse and exposure to domestic violence (Ryan, Hunter, & Murrie, 2014). As noted previously, PTSD is a frequent comorbid condition in juvenile females who engage in sexually abusive behavior, particularly those found in residential treatment centers (Ryan, Hunter, & Murrie). PTSD may lend itself to mood regulatory and impulse control problems (Hunter, Becker, & Lexier, as cited by Ryan, Hunter, & Murrie). Mood disturbances, histories of substance abuse, and problems of conduct are also closely associated with extensive trauma histories and are frequently found in female sexual offenders as well (Hickey et al., as cited by Ryan, Hunter, & Murrie).

Ignoring comorbid mental health disorders may compromise the efficacy of structured sex offender treatment (Ryan, Hunter, & Murrie, 2014). 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.

## **Assessment**

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 (O’Reilly & Dowling, 2008). During the assessment process, 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 may be helpful to consider full acknowledgment of offending behavior as a goal of treatment (O’Reilly & Dowling).

*The information in this section is taken from research compiled by the Center for Sex Offender Management (1999).* Professional evaluation of juveniles and their appropriateness for placement should be conducted post-adjudication and prior to court sentencing. Clinical assessments should be comprehensive and include careful record reviews, clinical interviewing, and screening for co-occurring mental health disorders.

The primary purpose of the assessment is to ascertain the risk of future sexual offending so that the most effective steps can be taken to reduce, contain, or eliminate risk (Rich, 2014). Hence, risk assessment essentially serves as an investigative tool that helps inform and guide various intervention, treatment, and legal processes. Most studies designed to assess the accuracy and validity of juvenile risk assessment instruments have focused on the overall structure and predictive accuracy of the most widely used instruments rather than on the individual risk factors within them. Since many of the risk factors used in these instruments have not been empirically validated, studies have produced inconsistent results (Rich). However, there is some empirical support for the capacity of risk assessment instruments to identify statistically valid risk factors as well as for the predictive validity of various instruments (Rich). Table 1 provides a listing of available assessment instruments currently available for juvenile sexual offenders.

**Table 1**  
**Assessment Tools for Juvenile Sexual Offenders**

<b>Assessment Tool</b>	<b>Description</b>
Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II)	Can be used either in a clinical or non-clinical setting. Assesses short term risk in juveniles between the ages of 12 and 18
Estimate of Risk of Adolescent Sexual Offence Recidivism (ERASOR)	Clinical assessment used to identify short term risk in juveniles between the ages of 12 and 18
Juvenile Sexual Offence Recidivism Risk Assessment Tool-II (J-SORRAT)	Actuarial assessment tool used to determine recidivism likelihood in convicted sexual offenders between ages 12 and 18
Juvenile Risk Assessment Scale (JRAS)	Clinical assessment used to determine the risk of a youth between the ages of 12 and 18
Structured Assessment of Violent Risk in Youth (SAVRY)	Not a formal judgment. Used in collaboration with other techniques to assess juvenile risk factors
Hare Psychopathy Checklist: Youth Version (PCL:YV)	Clinical interview used to assess possible negative behavioral patterns

Source: Center for Sexual Offender Management, 2007.

Studies conducted on the predictive accuracy of well-known risk assessment instruments showed differences in the predictive accuracies for general, violent, and sexual recidivism, and none of the instruments showed indisputable positive results in predicting future offending (Hempel et al., 2013). The two assessment tools with moderate predictive success are the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) and Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) (Hempel et al., 2013; Worling, Bookalam, & Litteljohn, 2012). ERASOR is also most effective in assessing non-Western offenders (Chu et al., 2012). One study asserted that other ways of assessing sexual risk should be developed, and because juveniles are rapidly developing, there is a need for reliable measures concerning short-term risk (Hempel et al.).

### ***Assessment of the Juvenile'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 of whether the parents are capable of providing supervision (Center for Sex Offender Management, 1999). 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.

### **Treatments**

Ethical issues have made it difficult to conduct controlled outcome studies on the treatment of juvenile sexual offenders. However, a number of encouraging clinical reports have been published with suggested treatment guidelines (Burton, Smith-Darden, & Frankel, 2006). Research has demonstrated that the overall prognosis for children with sexual behavior problems is good and that sexually abusive juveniles benefit from treatment (Farniff & Becker, 2006).

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. While juveniles are responsible for a significant portion of sexual offending, research on effective therapeutic interventions remain somewhat limited.

### ***Recommended Components***

A survey of professionals working with juvenile sexual offenders led to the identification of what may be considered recommended treatment components. Nominated components included anger management; correcting cognitive distortions about sexuality and relationships; fostering prosocial emotional, cognitive, and behavioral skills; and providing education about the offense cycle and pathways to sexual offending behavior (O'Reilly & Dowling, 2008). Parents or guardians need to be involved in the assessment and treatment process (Schladale, 2002). A summary of the recommended components of intervention programs for juvenile sexual offenders is provided in Table 2.

### ***Promising Treatment Approaches***

The following paragraphs discuss two promising treatment approaches: multisystemic therapy for problem sexual behaviors (MST-PSB) and cognitive behavioral therapy (CBT). Table 3 outlines treatments for sexually offending youth.

**Table 2**  
**Recommended Components of Intervention Programs for Sexually Offending Youth**  
**As Endorsed by Mental Health Professionals**

Treatment Component	Percent of Mental Health Professionals Endorsing
<b>Essential</b>	
Development of emotional competence skills, including management of anger/distress	93
Changing cognitive distortions about sexuality and relationships	90
Development of prosocial emotional, cognitive, and behavioral skills	87
Gaining an understanding of his/her offense cycle and/or pathways into sexually abusive behaviors	85
Sexuality education	85
Life space work (understanding boundaries and social interaction and the development of social skills)	84
Development of relapse prevention skills	84
Working with the family	82
Understanding the consequences of further abusive behavior	81
Development of empathy	81
<b>Desirable</b>	
Dealing with deviant sexual urges	79
Problem solving	71
<b>Additional</b>	
Promoting appropriate positive sexual thoughts, while changing sexually abusive thoughts	63

Source: O'Reilly & Dowling, 2008.

### **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 (Center for Sex Offender Management, 1999; National Institute of Justice, n.d).

Like standard multisystemic therapy, MST-PSB specifies a model of service delivery rather than a manualized treatment with sequential session content (Dopp, Borduin, & Brown, 2015). 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) (Dopp, Borduin, & Brown). 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). Treatment fidelity in MST-PSB is maintained by weekly group supervision meetings involving three to four therapists and a clinical supervisor and is monitored by an MST-PSB expert using a rigorous quality assurance system (Dopp, Borduin, & Brown).

**Table 3**  
**Summary of Treatments for Sexually Offending Youth**

<b>What Works</b>	
There are no evidence-based practices at this time.	
<b>What Seems to Work</b>	
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
<b>Not Adequately Tested</b>	
Pharmacological treatment	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.

MST-PSB has been evaluated in four studies treating juveniles with illegal sexual behaviors and has been shown to be beneficial for the treatment of these youth (Dopp et al., 2016). In one significant clinical study, the results demonstrated that MST-PSB was more effective than treatment as usual (cognitive-behavioral group therapy provided by a juvenile probation department) in decreasing youth’s deviant sexual interest/risk behaviors, delinquency, substance use, externalizing symptoms, and costly out-of-home placements at a 12-month post-recruitment follow-up (Dopp, Borduin, & Brown, 2015). A separate clinical study noted that MST-PSB was more effective than usual community services in improving individual symptomatology, family relations, peer relations, and academic performance (Borduin et al., as cited by Dopp, Bourduin, & Brown). Moreover, at follow-up, youth who had received MST-PSB had 83 percent fewer convictions for sexual crimes than youth receiving usual community services. MST-PSB participants also had lower recidivism rates for nonsexual crimes and spent 80 percent fewer days incarcerated than their counterparts (Borduin et al., as cited by Dopp, Bourduin, & Brown).

**Cognitive Behavioral Therapy (CBT)**

CBT is the most common modality employed by community and residential treatment programs for juvenile sexual offenders (Dopp, Borduin, & Brown, 2015). 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 (National Institute of Justice, 2015). 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.

### ***Pharmacological Interventions***

*The information in the following paragraph is from Ryan, Hunter, and Murrie (2014).* Pharmacologic interventions may be helpful in the treatment of juvenile sexual offenders, but they should be carefully considered and utilized with caution. It is important to recognize that youth who sexually offend may also have co-occurring psychiatric disorders such as mood disorders, ADHD, thought disorders, and anxiety disorders. These disorders should be addressed with the appropriate evidence-based treatment. Treatment with pharmacologic agents that target sexually deviant behavior should always be provided on a voluntary basis, and patients and guardians should be educated about the lack of FDA approval for the use of these medications as well as the limited research regarding effectiveness. 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.

In treating sexual offenders, selective serotonin reuptake inhibitors (SSRIs) have been shown to have an impact on sexual preoccupations, sexual drive, and arousal (Shaw, 1999). Further information about SSRIs is provided in the “Antidepressants and the Risk of Suicidal Behavior” section of the *Collection*.

Treating sexual offenders through the use of antiandrogen drugs should be reserved for the most severe sexual abusers and is discouraged for use in juvenile sexual offenders under age 17 (Shaw, 1999). These drugs should never be used as an exclusive treatment (AACAP).

### ***Other Treatment Considerations***

#### **Community-based Programming**

Recent research suggests that community-based programming can offer certain advantages, including shortening residential lengths of stay, reducing the number of juvenile sexual offenders placed in residential care settings, and improving the post-residential transitioning of youth back into community settings (Hunter et al., 2004). Key concepts guiding community-based programming are recognition of the heterogeneity of the population, establishment of a seamless continuum of care, emphasis on the myriad of problems this population manifests, and integration of legal and clinical management (Hunter et al.). Risk assessments guide critical decisions involving treatment intensity, supervision requirements, confinement to secure facilities, and whether a youth should be confined to a secure facility. Other guidelines to be considered when making determinations about level of care include equal emphasis on the need to:

- Maintain public safety;
- Hold offenders accountable; and
- Present offending youth with the opportunity to receive specialized treatment designed to reduce their risk of reoffending (Waite, as cited by Ryan, Hunter & Murrie, 2014).

When these elements are considered, community-based programming can be an effective element to the treatment continuum for juvenile sexual offenders. Critical to the success of community treatment is the careful integration of clinical and legal supervisory services.

### **Residential Sexual Offender Treatment**

Juveniles who have significant offending histories and/or are deemed to be at a high risk to sexually re-offend are appropriate for residential sexual offender treatment. This would include those juveniles who have had multiple victims and/or have engaged in more invasive sexual offending behavior (Ryan, Hunter, & Murrie, 2014). Many of these youth have histories of substance abuse and/or treatment failure.

Residential treatment ensures public and community safety and simultaneously provides juveniles with intensive treatment that can address both sexual and non-sexual behaviors. Residential programs provide intensive treatment delivered by trained staff in a highly structured treatment setting. The key to a successful residential programming is individualizing the treatment, which allows each juvenile to address the unique and specific issues that are relevant, so they can gain control over their sexual and non-sexual behaviors. As a result, the length of time a juvenile remains in the program will vary, depending on the severity of the juvenile's problematic behaviors and motivation in treatment.

In a study of 668 juveniles in residential sexual offender programs within Virginia's juvenile correctional centers, the recidivism rate based on re-arrests for sexual offenses was four percent (with an average time post-release of 4½ years) (Wieckowski et al., 2005). The projected recidivism rate for sexual offenses was 7.7 percent when based on all juveniles reaching the 10-year post-release mark (Waite et al., 2005). Successful reentry from residential program to the community was based on receiving ongoing community-based services. Juveniles who successfully complete residential programs responded best when they were provided a gradual reduction in supervision and treatment services based on their compliance with parole rules and application of material they learned in treatment.

*The following information is taken from Ryan, Hunter, & Murrie (2014).* It is critical that clinicians and juvenile justice professionals tasked with making disposition recommendations comprehend the implications of either under or overprescribing interventions for juvenile sexual offenders. Placement of high-risk youth in community-based programs with few external controls obviously raises the risk of the youth perpetrating new sexual and/or nonsexual offenses. These offenses not only bring harm to their victims but also lead to new, and perhaps more serious, legal and social consequences. Conversely, placing low-risk juveniles in a correctional or residential setting with juveniles who are more antisocial or sexually deviant can result in unintended and even detrimental treatment effects (Poulin, Dishion, & Burraston, as cited by Ryan, Hunter, & Murrie). For these reasons, thorough assessment is critical.

### **Incorporating Trauma-Informed Care**

Clinicians should consider incorporating principles of trauma-informed care into evidence-based sex offender treatment models. Early adverse experiences are prevalent in sex offender populations. Early trauma paves the way for maladaptive coping and interpersonal deficits, which can lead to abusive behavior. Content-oriented sex offender treatment models should integrate process-oriented components that address the ways in which early trauma shapes cognitions and behaviors. Relational approaches to therapy can enhance the youth's interpersonal skills while improving their general well-being. This may mitigate future offending as the youth adopts and successfully practices healthier, non-destructive strategies for meeting emotional needs (Levenson, 2014).

## 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 (VDJJ, 2016).

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 (VDJJ, 2016).

VDJJ has previously collected data on the effectiveness of this program. This data indicated that sexual recidivism rates for juvenile sexual offenders was lower than that for adult offenders and that youth participating in a self-contained sexual offender treatment program were less likely to participate in criminal activity after release. This is particularly true for the non-sexual assault offenders. The data offered two important findings:

1. Rates of recidivism, based on rearrests, for sexual offenses among juvenile sexual offenders are low and are not based on the type of treatment during incarceration; and
2. High impulsive/antisocial behaviors significantly increase the probability of recidivism, regardless of type of treatment during incarceration (Wieckowski et al., 2005).

In fiscal year 2016, over 11 percent of direct care admissions had a sex offender treatment need. Recidivism rates for juveniles assigned sex offender treatment needs were lower than rates for juveniles assigned aggression management or substance abuse treatment needs. The 12-month recidivism rates for juveniles receiving direct care sex offender treatment was 27 percent for fiscal year 2014. Conversely, the 12-month recidivism rates for juveniles receiving substance abuse treatment and aggression management was about 43 percent and 41 percent.

## Qualifications of Sex Offender Treatment Providers

Due to the potential risk to the community from ineffective treatment for sexual offenders, the Virginia General Assembly passed legislation in 1997 (Chapter 556) to create a certification process for clinicians who provide service to sexual offenders. While licensed practitioners are required to practice only within the scope of their expertise (i.e., one could not provide sex offender treatment unless qualified to do so), a certification as a sexual offender treatment provider (CSOTP) offers additional evidence of a specific expertise in this area. 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. Face-to-face supervision obtained in a group setting shall include no more than six trainees in a group (Virginia Board of Psychology, *Regulations Governing the Certification of Sex Offender Treatment Providers*, 18 VAC 125-30 et seq.).

## **Recidivism: Research and Current Trends**

Studies on sexual offending among youth suggest that, although the majority of adolescents who commit sexual offenses do not continue offending into their twenties, somewhere between 9 percent and 15 percent do (Nisbet, Wilson, & Smallbone, as cited by Chu & Thomas, 2010). Researchers are beginning to illuminate various risk factors associated with juvenile sexual re-offending in order to further propel the establishment of effective means of assessment and treatment within this population. Empirically-supported risk factors include deviant sexual interest (e.g., sexual interest in children and/or sexual violence), prior criminal sanctions for sexual offending, sexual offending against more than one victim, sexual offending with a victim not known to the offender, social isolation, and uncompleted offense-specific treatment (Worling & Langstrom, as cited by Rich, 2014). Moreover, specialized sex offender treatment may not reduce the risk of subsequent nonsexual delinquency by juvenile sexual offenders. Between one fourth and one half of sexually abusive youth engage in nonsexual delinquency following treatment (Ryan, Hunter, & Murrie, 2014). Therefore, presently available data support the belief that sexual behavior problems in youth are often present with broader psychopathology and system dysfunction. Accordingly, treatments must extend beyond the sexual behavior problem to be effective in helping these youth learn to lead productive lives.

## **Controversial Areas of Practice**

Some areas of practice are considered ethically and legally controversial and may create special problems for juvenile sexual offending service providers (Center for Sex Offender Management, 1999; National Center on the Sexual Behavior of Youth, 2012). These include pre-adjudication evaluations, sexual offense risk assessments, polygraphs, and phallometric assessments (e.g., a type of assessment to determine sexual attraction). The issues surrounding these areas of practice relate both to their lack of overall effectiveness and lack of validity within a juvenile population.

## **Conclusion**

While there appears to be a scarcity of literature regarding evidence-based treatment programs for juvenile sexual offenders, some assessment methodologies and treatments appear promising. It is expected that future research will offer a clearer understanding of juvenile sexual offenders, further refine essential and supplemental components of effective interventions, and comprehensively assess and identify youth who are at high risk of re-offending sexually. Until then, research showing that current treatment practices can be effective overall with this population is promising and offers hope for reduced rates of recidivism.

## **Resources and Organizations**

**American Academy of Child & Adolescent Psychiatry (AACAP)**

<https://www.aacap.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/>

**Virginia Department of Juvenile Justice (VDJJ)**

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

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