

S EXUAL OFFENDING

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Introduction

Juveniles who perpetrate sexual offenses are defined as those who commit any sexual act against the victim's will, without consent, or in an aggressive, exploitive, or threatening manner (Matthews, 1997). These juveniles are usually between 12 and 17 years of age and are mostly male, although some studies have found a number of females and prepubescent perpetrators (Hunter, 2000). Sexually abusive behaviors can vary from non-contact offenses to acts of penetration (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2001). These sexually abusive juveniles should not be considered to be engaging in normative "teenage experimentation," as their behaviors have the potential to cause significant harm to others (O'Reilly & Dowling, 2008).

Juvenile sexual offending is a serious problem which is increasingly becoming a focus of attention and concern. Each year in the United States, an estimated one-fifth of reported rapes are committed by juveniles; one-half of the child molestations are committed by juveniles (Hunter, 2000). Approximately half of all adult sexual offenders began their criminal careers during adolescence (Saleh & Vincent, 2004). The Federal Bureau of Investigation (FBI) reported in 2001 that approximately 12% of all rapes resulted in the arrest of a juvenile (Saleh & Vincent). In fiscal year 2008-2009 in Virginia, over 7% of the admissions to the Department of Juvenile Justice (DJJ) were for a sexual offense (DJJ, 2009).

Juvenile sexual offenders are a diverse population, which makes it difficult to attribute universal causal factors to their offending behaviors. However, research is beginning to make strides in understanding this population and the associated risk factors. Research with this population has shown that there are two types of juvenile sexual offenders: those who target children and those who offend against their peers or adults (Hunter, 2000). The type of offense is based on factors such as the age and sex of the victim, the relationship between the victim and the offender and the amount of force used (OJJDP, 2001).

Characteristics of Juvenile Sexual Offenders

Sexual and physical abuse, child neglect, and exposure to family/domestic violence are associated with juvenile sexual offending (Center for Sex Offender Management, 1999). Juvenile sexual offenders may be characterized as loners with few close friends (Thakur, as cited by Kushner, 2004). Exposure to pornography has also been cited, but studies examining whether pornography leads to juvenile sexual offending have been inconclusive (OJJDP, 2001). Likewise, an association between substance abuse and juvenile sexual offending has not been fully established (Center for Sex Offender Management). Table 1 outlines the characteristics of sexually abusive juveniles.

Research has provided several promising leads to understanding the juvenile sexual offender. A significant proportion have a prior arrest for a nonsexual offense and/or meet the criteria for a diagnosis of conduct disorder. In addition, juvenile sexual offenders may present with a diverse range of disordered

behaviors, including aggressive behavior, bullying, vandalism, fire setting, cruelty to animals, shoplifting and drug/alcohol abuse. Furthermore, while rates of sexual reoffending are generally low-to-moderate for this population overall (8 to 15%), evidence suggests that youth who have offended sexually, especially when they also possess a high degree of antisocial tendencies, have an extremely high risk of reoffending overall when profiles include non-sexual charges (46 to 54%) (O'Reilly & Carr, 2006; Worling & Langstrom, 2006).

Table 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% have a diagnosable psychiatric disorder. 30 to 60% exhibit learning disabilities and academic dysfunction. 20 to 50% have histories of physical abuse. 40 to 80% have histories of sexual abuse.

Sources: Center for Sex Offender Management, 1999; Hunter, 2000.

Juvenile Female Sexual Offenders

There are few studies that address juvenile female sexual offenders. Due to 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, 2004). For instance, reoffense rates for females and males cannot be compared because sexual and non-sexual reoffense rates for female sexual offenders are not known (National Center on Sexual Behavior of Youth).

While these studies have limitations, they have been helpful in identifying implications for treating juvenile female sexual offenders. Female sexual offenders are usually more likely to have histories of maltreatment, with physical abuse being apparent in 20% of studied cases and sexual abuse, in 50% of studied cases (Mathews, Hunter & Vuz, 1997). Compared to those of juvenile males, the histories of the studied females 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). Moreover, their histories revealed that they were victimized at younger ages and were more likely to have had multiple perpetrators (Mathews, Hunter & Vuz). In samples of prepubescent female sexual offenders, rates of sexual victimization tend to be extraordinarily high (i.e., greater than 90%) (Hunter, Becker & Lexier, 2006). Preliminary research has revealed that these females had very disruptive and tumultuous childhoods, with high levels of trauma and exposure to dysfunction. Post-traumatic stress disorder (PTSD) has been found to be especially prevalent (Hunter, Becker & Lexier). High levels of impulsive delinquent behaviors, including substance abuse and other high-risk behaviors, were also observed (Mathews, Hunter & Vuz).

Juvenile female sexual offenders may molest youth of both genders, with the victims typically being relatives or acquaintances (Mathews, Hunter & Vuz, 1997). Female juvenile offenders do not tend to abuse children unknown to them (Mathews, Hunter & Vuz). Many of the victims of female sexual offenders were molested frequently in the context of babysitting. There is little evidence to suggest that female juveniles, unlike female adults, sexually offend within the context of a relationship with male co-offenders (Hunter, Becker & Lexier, 2006).

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 because they were validated on male offenders and have not yet been empirically validated with a female population. 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. Further, 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

Juvenile sexual offenders may share some characteristics other than sexual offending, including:

- high rates of learning disabilities and academic dysfunction;
- the presence of other behavioral problems and conduct disorder; and
- difficulties with impulse control and judgment. (Saleh & Vincent, 2004).

Rates of psychiatric disorders among juvenile sexual offenders have been shown to range from 37 to 87% (O'Reilly & Dowling, 2008). As suggested, a significant proportion of this population's sexual offending behaviors may be attributed to a larger pattern of conduct-disordered traits. Furthermore, juvenile sexual offenders may have also demonstrated characteristics of paraphilia, which is an intense, repeated sexual arousal to unconventional stimuli (PsychDirect, 2004). Offenders with paraphilia tendencies were also reported to have high rates of psychiatric disorders (Saleh & Vincent, 2004). Within a recent study of juvenile sexual offenders, 95% had two or more paraphilias, 82% had a mood disorder, 55% had an anxiety disorder, 55% had an impulse control disorder, 71% had attention deficit hyperactivity disorder (ADHD), 94% had conduct disorder (CD), and 50% had a substance abuse disorder (Saleh & Vincent).

Assessment

Careful screening is critical to match a juvenile's needs to the type and level of treatment, which can range from community-based programming to intensive residential treatment. Ideally, assessment reflects careful consideration of the danger that the juvenile presents to the community, the severity of psychiatric and psychosexual problems, and the juvenile's amenability to treatment. Community-based programs should not compromise community safety by admitting juveniles who are aggressive and violent (O'Reilly & Dowling, 2008).

All available participants should be included within the assessment process, including the youth, 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 young person and his or her family may be at various psychological points, ranging from complete denial to full acknowledgment of the sexual offense(s), and thus it may be more helpful to consider full acknowledgment of offending behavior as a goal of treatment (O'Reilly & Dowling).

Clinical Assessment

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.

Assessment of the Juvenile's Home

Assessments of the juvenile's appropriateness for community-based programming should include a thorough review of his living arrangements, as well as a determination of whether the parents are capable of providing supervision (Center for Sex Offender Management, 1999). It is essential that the community and other children are protected from potential harm, both physical and psychological.

Treatments

Funding problems and ethical issues have made it difficult to conduct controlled outcome studies on the treatment of juvenile sexual offenders. Accordingly, no evidence-based treatment guidelines have been established for juvenile sex offenders. However, a number of encouraging clinical reports have been published, and guidelines have been suggested per expert opinion and currently accepted clinical practice (Burton, Smith-Darden & Frankel, 2006). Research to date 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).

Juvenile sexual offenders differ from their adult counterparts in that juveniles generally do not present the same kinds or levels 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 reoffending (Trivits & Reppucci, 2002).

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 are unfortunately lacking. Additional information about juvenile sexual offender treatment programs are outlined below.

Recommended Components

Given the lack of empirically supported treatments, 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, cognitive distortions about sexuality and relationships, fostering of prosocial emotional, cognitive, and behavioral skills and development of an understanding of 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). The use of family therapy may be most beneficial in instances where incest has occurred, especially when the sexual offender will be rejoining the family after treatment (American Academy of Child & Adolescent Psychiatry, [AACAP], 1999).

A summary of the recommended components of intervention programs for juvenile sex offenders is provided in Table 2. Given the lack of studies, these components are not considered evidence-based.

Promising Treatment Approaches

The following paragraphs discuss two promising treatment approaches: Multisystemic Therapy (MST) and residential sexual offender treatment.

Multisystemic Therapy

MST, which has been evaluated in two randomized trials treating highly delinquent juvenile sex offenders, has been shown to be beneficial for the treatment of these youth (Borduin & Schaeffer, as cited by Chaffin & Friedrich, 2004). MST is an intensive family- and community-based treatment which addresses the multiple factors of serious antisocial behavior in juvenile sexual abusers. Treatment can involve any combination of the individual, family and extra familial factors (e.g., peer, school, or neighborhood). MST 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).

Table 2

**Recommended Components of Intervention Programs
for Sexually Offending Youth**

As Endorsed by Mental Health Professionals

Treatment Component	% of Mental Health Professionals Endorsing
Essential	
Development of emotional competence skills, including the management of anger and 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
Desirable	
Dealing with deviant sexual urges	79
Problem solving	71
Additional	
Promoting appropriate positive sexual thoughts, while changing sexually abusive thoughts	63

Source: O'Reilly & Dowling, 2008.

In perhaps the best controlled study to date, MST was compared to individual therapy in the outpatient treatment of 16 juvenile sexual offenders. Using re-arrest records as a measure of recidivism (sexual and non-sexual), the two groups were compared at a three-year follow-up interval. Results revealed that juveniles receiving MST had recidivism rates of 12.5% for sexual offenses and 25% for non-sexual offenses, while juveniles receiving individual therapy had recidivism rates of 75% for sexual offenses and 50% for non-sexual offenses (Hunter, 2000).

Residential Sexual Offender Treatment

Juveniles who have significant offending histories and/or are deemed to be at a high risk to sexually reoffend are appropriate for residential sexual offender treatment. Residential treatment ensures public and community safety and simultaneously provides juveniles with intensive treatment which 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 to gaining 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 one recent 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 4% (with an average time post-release of 4½ years) (Wieckowski, Waite, Pinkerton, McGarvey & Brown, 2005). The projected recidivism rate for sexual offenses was 7.7% when based on all juveniles reaching the 10-year post-release mark (Waite et al., 2005). Successful reentry from residential program to community is based on receiving on-going, community-based services. Juveniles who successfully complete residential programs respond best when they are provided a gradual reduction in supervision and treatment services based on their compliance with parole rules and application of material they learned in treatment.

Other Treatments

In treating sexual offenders, selective serotonin reuptake inhibitors (SSRIs) have been shown to have an impact on sexual preoccupations, sexual drive and arousal (AACAP, 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 for juvenile sexual offenders under age 17 (AACAP, 1999). These drugs should never be used as an exclusive treatment (AACAP).

Other Treatment Related Information

The following paragraphs discuss additional information of interest.

Community-based Programming

Community-based programming for juvenile sexual offenders is gaining more attention. 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, Gilbertson, Vedros & Morton, 2004). Economic and clinical considerations have also bolstered the need for effective community-based programming. 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, Gilbertson, Vedros & Morton). Community-based programming is an effective element to the treatment continuum for juvenile sexual offenders.

Virginia's Sexual Offender Treatment Program

The following information about Virginia's Juvenile Sexual Offender programs is from a personal communication with Arthur Mayer, LCSW and certified sexual offender treatment provider (CSOTP) (May 13, 2010). The Department of Juvenile Justice (DJJ) opened its first state-operated juvenile sexual offender treatment unit in January 1990. The program has significantly expanded since that time to meet the growing number of sexual offenders in the system. As of May 2010, the Department has 11 self-contained sexual offender treatment units across five juvenile correctional centers (JCCs). Beaumont and Culpeper JCCs offer treatment to older juveniles; Hanover and Bon Air JCCs, to younger high school and middle school juveniles; and Oakridge JCC, to developmentally delayed juveniles of all ages. The overall sexual offender program is managed by the Program Supervisor of Sexual Offender Services (Edward Wieckowski, MA, CSOTP).

Currently, there are approximately 250 sex offenders in Virginia's JCCs. Of these, 170 are placed in the self-contained units, while the remaining juveniles have completed treatment and are serving the remainder of their incarceration time, or are on the waiting list to enter treatment. There are also a handful of juveniles with minimal sexual offending behavior whose treatment needs can be met outside a self-contained unit. The length of time a juvenile remains in the self-contained unit is based on severity of offense and motivation in treatment, and averages 14-18 months.

The self-contained units offer intensive milieu-based treatment where juveniles reside in housing units with other sexual offenders. The units offer a range of treatment modalities that include individual and group psychotherapy, psycho-educational groups and family psychotherapy. They are typically staffed by a psychologist senior, clinical social worker, institutional counselor, and juvenile correctional officers (JCOs). The clinical staff at JCCs are either licensed or certified as sexual offender treatment providers (CSOTPs).

Juvenile sexual offenders are a heterogeneous population. Treatment is individualized by the therapists "Individualized Treatment Plan" protocol. All juveniles work toward ten general goals by completing a minimum of eight designated core treatment activities. They must also complete any identified individualized treatment activities.

In 2005, DJJ 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 sex 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).

Qualifications of Sex Offender Treatment Providers

The following information is derived from a personal communication with Dennis Waite, Ph.D. (December 18, 2007). Due to the potential risk to the community of ineffective treatment for sex offenders, the Virginia General Assembly passed legislation in 1997 to create a certification process for clinicians who provide service to sex 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 sex offender treatment provider (CSOTP) offers additional evidence of a specific expertise in this area. When seeking professional services for sex offenders, it is prudent to ensure that the qualifications of the service provider indicate expertise in the treatment of sex offenders. One way to ensure such expertise is to select a professional with this certification (CSOTP). Qualifications include a minimum of a Master's Degree in selected fields, 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 sex offenders, and 100 hours of clinical supervision (Virginia Board of Psychology, *Regulations Governing the Certification of Sex Offender Treatment Providers*, 18 VAC 125-30 et seq.).

Recidivism: Research and Current Trends

The following information is taken from Worling and Lanstrom (2006). Researchers are beginning to illuminate various risk factors associated with juvenile sexual reoffending in order to further propel the establishment of effective means of assessment and treatment with 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.

Identified risk factors that have been linked to reoffending include problematic parent-adolescent relationships and attitudes supportive of sexual offending. These risk factors are still being studied and have not yet been fully confirmed empirically. Possible risk factors, which have also yet to be empirically validated, include high stress family environment, impulsivity, antisocial interpersonal orientation, interpersonal aggression, negative peer associations, sexual preoccupation, sexual offending against a male victim, sexual offending against a child, threats, violence, or weapons in a sexual offense and an environment supporting reoffending.

Finally, risk factors which should not be used in formulating risk estimates for juvenile sexual offenders include the juvenile's own history of sexual victimization, history of nonsexual offending, sexual offending involving penetration, denial of sexual offending and low victim empathy.

Controversial Treatments

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). 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 treatments relate both to their lack of overall effectiveness and validity within a juvenile population.

Conclusion

While there appears to be a scarcity of literature regarding evidence-based treatment programs for juvenile sexual offenders, there are promising directions for assessment and treatment implications for this population. It is expected that future research will successfully offer further better understanding of juvenile sexual offenders and their families, further refine essential and supplemental components of effective interventions, and comprehensively assess and identify youth who are at high risk of reoffending 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.

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Organizations

American Academy of Child & Adolescent Psychiatry (AACAP)

www.aacap.org

Focus Adolescent Services

Adolescent Sex Offenders

<http://www.focusas.com>

Institute for Family Centered Services (IFCS)

<http://www.ifcsinc.com>

Juvenile Forensic Evaluation Resource Center

Sex Offender Programs

<http://www.ilppp.virginia.edu/training-symposia/sex-offender-programs.html>

Virginia Department of Juvenile Justice (DJJ)

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

National Center on Sexual Behavior of Youth

<http://www.ncsby.org>