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Child Sexual Molestation: Research Issues

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Child Sexual Molestation: Research Issues

Executive Summary

Over the past 25 years, the problem of child sexual victimization has received significant attention from researchers, clinicians, and policymakers. Yet underreporting of sexual offenses against children has made it impossible to gauge either the frequency of such incidents or the size of victim and offender populations. In addition, deficient research methodologies have yielded incompatible or contradictory findings with regard to the characteristics, motivations, and recidivism rates of offenders. As a result, critical decisions about offender dangerousness, control, and treatment have been made in the absence of a sound knowledge base. In recent years, however, efforts have been made to (1) develop and validate an empirically based model of the agents and factors that lead to child sexual abuse, and (2) design and test statistical methods for assessing reoffense risk.

Important findings:

- The classification, diagnosis, and assessment of child molesters are complicated by a high degree of variability among individuals in terms of personal characteristics, life experiences, criminal histories, and reasons for offending. There is no single “profile” that accurately describes or accounts for all child molesters.
- Sexual focus in child molesters has two independent dimensions: intensity of pedophilic interest and exclusivity of the sexual preference for children. The more an offender’s sexual preference is limited to children, the less socially competent (as measured by the strength and range of social and sexual relationships with adults) he is likely to be.
- Most victims of childhood sexual abuse do not go on to become child molesters. However, sexual victimization as a child, if accompanied by other moderating factors—such as the co-occurrence of other types of abuse—may contribute to the child-victim’s later emergence as a perpetrator of child sexual abuse. Similarly, social competence deficits are clearly significant in child molestation, but an individual’s inadequate social and interpersonal skills do not, by themselves, make his sexual abuse of children inevitable.
- A history of impulsive, antisocial behavior is a well-documented risk factor for certain predatory, extrafamilial child molesters; offenders who have this background and who began their offending careers in adolescence have also evidenced higher degrees of nonsexual aggression.
- Early childhood experiences, such as a high turnover in primary caregivers (which is a strong predictor of adult sexual violence), may interfere with the development of viable, age-appropriate adult relationships, making it more likely that children are selected as sexual targets.
- Physiological arousal to children often accompanies a sexual interest in them. Phallometric assessment of sexual arousal in response to depictions of children can differentiate child molesters from nonmolesters, same-sex molesters from opposite-sex molesters, and extrafamilial molesters from incest offenders.

- An empirical classification typology for child molesters, based on stable traits that have identifiable roots in childhood, is being developed by NIJ-supported researchers. Known as MTC:CM3, the system classifies child molesters according to variables on two coordinates: the first focuses on fixation and social competence, and the second focuses on contact with children, injury to victim, and sadism. The system is an important first step in the design of research on etiology, treatment, disposition, and prognosis. Although further revision and refinement of the typology are necessary, studies support the reliability and validity of the classification structure.
- Recidivism rates across studies are confounded by differences in legal guidelines and statutes among States, length of exposure time (i.e., time in the community, where the opportunity exists to reoffend), offender characteristics, treatment-related variables (including differential attrition rates, amount of treatment, and integrity of treatment program), amount and quality of posttreatment supervision, and many other factors.
- A 25-year followup study of 111 extrafamilial child molesters included extensive data from criminal justice records and rationally derived composites of variables. The study demonstrated an ability (1) to discriminate among offenders who committed sexual crimes involving physical contact with a victim, nonsexual crimes involving physical contact with a victim, and nonsexual crimes in which no physical contact with a victim occurred and (2) to predict reoffense probabilities with reasonable accuracy. If these results can be replicated in studies of other offenders, use of a scale based on archival records may represent an easy, cost-effective, and reliable substitute for intrusive and time-consuming physiological assessment.
- Although optimal treatment interventions have yet to be identified, the most effective intervention to date—cognitive behavior therapy and, when appropriate, antidepressant and antiandrogen medication—has reduced recidivism among child molesters.
- Intensive community-based supervision and management of child molesters are essential to reduce sexual victimization rates; child abusers have been known to reoffend as late as 20 years following release into the community.

Introduction

Few criminal offenses are more despised than the sexual abuse of children, and few are so little understood in terms of incidence (the number of offenses committed), prevalence (the proportion of the population who commit offenses), and reoffense risk. Despite longstanding public concern over the medical, emotional, and monetary costs associated with child sexual victimization, rigorous programs to enhance the accuracy of predictive decisions involving sexual offenders are of fairly recent origin. Because of inadequate methodologies, studies on the psychology, behavior, treatment, and recidivism rates of child molesters have often yielded inconsistent findings. The uncertainty of information about sexual offenders raises questions about the effectiveness of special commitment statutes and ad hoc discretionary and dispositional decisions directed toward this group.

Before it can combat child molestation effectively, the criminal justice community must first understand it. Empirical knowledge of the factors that lead individuals to sexually abuse children can support and inform the sentencing, probationary, clinical, and supervisory decisions that must be made with regard to child molesters. This report is divided into four main sections. Section 1 discusses the frequency of child sexual molestation and factors leading to sexual deviancy in individual offenders. Section 2 includes classification models for typing and diagnosing child molesters and describes treatment approaches and strategies for community-based maintenance and control. Section 3 talks about reoffense risk as it relates to criminal justice decisions and discusses predictors of sexual recidivism. To illustrate the variability of recidivism among child molesters, section 4 presents the findings of a 25-year followup study of 115 released offenders. Finally, some of the shortcomings of current approaches to reduce child molester reoffense risk are touched on in the report's conclusion, and an argument is made for postrelease treatment and aftercare programs.

The information included in this Research Report has been distilled from several interrelated reports

and studies sponsored by the National Institute of Justice (NIJ) to strengthen the efficacy of intervention and prevention strategies and ultimately reduce child sexual victimization rates.

Section 1. Occurrence and Etiology

Frequency of Child Sexual Abuse

The assumption that sexual crimes against children and teenagers are underreported is now commonly accepted. Sexual offenses apparently are more likely than other types of criminal conduct to elude the criminal justice system. This inference is supported by the reports of both sex offenders and sexually abused children. Offenders report vastly more victim-involved incidents than those for which they were convicted (see "Adult Reports of Child-Focused Sexual Behavior").¹ It is impossible to determine how representative these anonymous self-reporting offenders are, compared to all of the nonincarcerated and unidentified sex offenders in the population.

A telephone survey of a national probability sample of 2,000 children between the ages of 10 and 16 revealed that 3.2 percent of girls and 0.6 percent of boys had suffered, at some point in their lives, sexual abuse involving physical contact. If one infers that those statistics can be generalized to the rest of the country, children have experienced (but not reported) levels of victimization that far exceed those reported for adults.² This finding is consistent with a recent report indicating that teenagers are at greater risk than adults for rape.³

In addition to underreporting, incidence estimates are also affected by a number of methodological problems. Although research on criminal conduct of any type may be hampered by these difficulties, sexual crimes seem to be especially susceptible. For instance, sexual offenses involve behavior that is not as clear-cut as that occurring in nonsexual crimes (such as robbery, burglary, or auto theft) because they often include nonsexual offenses (e.g., kidnaping, breaking and entering, or simple assault) as well as a variety of different sexual violations. The criminal charges springing from such a litany differ from one

Adult Reports of Child-Focused Sexual Behavior

Perhaps the most dramatic offender self-report data on victimization rates come from research in which investigators recruited 561 subjects through a variety of means (e.g., health care workers, media advertising, and presentations at meetings).^a The offenders were given a lengthy structured clinical interview covering standard demographic information as well as history of deviant sexual behavior. The 561 subjects reported a total of 291,737 “paraphilic acts” committed against 195,407 victims under the age of 18. The five most frequently reported paraphilic acts involved criminal conduct:

- Nonincestuous child molestation with a female victim (224 of the 561 subjects reported 5,197 acts against 4,435 victims).
- Nonincestuous child molestation with a male victim (153 of the 561 subjects reported 43,100 acts against 22,981 victims).
- Incest with a female victim (159 of the 561 subjects reported 12,927 acts against 286 victims).
- Incest with a male victim (44 of the 561 subjects reported 2,741 acts against 75 victims).
- Rape (126 of the 561 subjects reported 907 acts against 882 victims).

The remaining sixteen categories included a wide range of paraphilias, which may or may not have involved coercion. The first five categories included a total of 64,872 acts. The total number of subjects and victims cannot be determined since the categories are overlapping (i.e., many subjects reported multiple paraphilias and hence were recorded in multiple categories).

^a Abel, G.G., J.V. Becker, M.S. Mittelman, J. Cunningham-Rathner, J.L. Rouleau, and W.D. Murphy, “Self-Reported Sex Crimes of Nonincarcerated Paraphilics,” *Journal of Interpersonal Violence* 2 (1987):3–25.

jurisdiction to another, and the resulting conviction may be for a “lesser,” that is, nonsexual, offense (e.g., pleading out to simple assault). Given this unevenness in legal system dispositions, it is not surprising to find wide variations among—and wide ranges within—incidence/prevalence estimates.

Characteristics of the Offender

The sexual abusers of children are highly dissimilar in terms of personal characteristics, life experiences, and criminal histories. No single “molester profile” exists. Child molesters arrive at deviancy via multiple pathways and engage in many different sexual and nonsexual “acting-out” behaviors.

Sexual focus. Evidence shows that sexual focus in child molesters comprises two separate components. The first is intensity of pedophilic interest, i.e., the degree to which offenders are focused or “fixated” on children as sexual objects. The second component

involves the exclusivity of their preference for children as sexual objects. The second component is inversely related to social competence, as measured by the extent and depth of adult social and sexual relationships, and it is independent of the intensity of pedophilic interest.

Physiological arousal. Logic suggests that a behavioral dimension of sexual interest in children would be accompanied by varying degrees of physiological arousal to them. Plethysmographic assessment (i.e., measurement of penile volume changes [phallometry] in response to sexual stimuli) has demonstrated an ability to discriminate between child molesters and comparison groups of nonmolesters,⁴ as well as among subgroups of child molesters defined by victim gender preference (same sex vs. opposite sex) and by relationship to victim (incest vs. nonincest). For example, exclusive incest offenders demonstrate far less sexual arousal in response to children than do extrafamilial child molesters.

Offenders with strong pedophilic interest show more sexual arousal to depictions of children than their low-fixated counterparts.

Victimization of offenders as children. Some support exists for the notion that child molestation may be related to an offender's restaging or recapitulation of his own sexual victimization. Tests of the recapitulation theory on a sample of 131 rapists and child molesters revealed that child molesters who committed their first assault when they were 14 or younger were sexually victimized at a younger age than offenders who committed their first assault in adulthood; they also experienced more severe sexual abuse than offenders with adult onset of sexual aggression.⁵ No evidence of recapitulation of sexual abuse among rapists was found in this study. It should be pointed out, however, that regardless of whether or not they were sexually abused (and, if so, by whom and at what age), *all* offenders in the sample went on to commit sexual offenses.

By itself, sexual victimization is too narrow a factor to explain child molestation. No inexorable link exists between experiencing sexual abuse as a child and growing up to be a child molester; the "outcome" of child molestation is a much more complex phenomenon. Most victims of childhood sexual abuse do not go on to become perpetrators. As is true for other kinds of maltreatment, childhood sexual victimization becomes a critical element in the presence or absence of a variety of other factors (e.g., co-occurrence of other types of abuse, availability of supportive caregivers, ego strength of child-victim at the time of abuse, and treatment), all of which moderate the likelihood of becoming a child molester. In addition, the severity of the long-term effects of childhood sexual abuse is influenced by clear morbidity factors (e.g., age at onset of abuse, duration of abuse, the child's relationship to the perpetrator, and invasiveness and/or violence of the abuse). The weight and significance of having been sexually abused are specific to the individual child molester.

Social competence. A variety of studies have documented the inadequate social and interpersonal skills, underassertiveness, and poor self-esteem that,

in varying degrees, characterize individual offenders.⁶ Social competence deficits are pervasive among child molesters and must be considered clinically significant. As is true for sexual abuse suffered by offenders during childhood, however, social competence deficits constitute but one important factor in the complex etiology of child molestation.

Impulsive, antisocial personality. Research shows that child molesters who committed their first sexual offense in adolescence had histories of being disruptive in school (verbally or physically assaulting peers and teachers), showed high levels of juvenile antisocial behavior, and, as adults, manifested a greater degree of nonsexual aggression. For some types of child molesters,⁷ sexual offenses are part of a longer criminal history, reflecting an antisocial lifestyle and impulsive behavioral traits that probably had been present from childhood.⁸ A history of impulsive, antisocial behavior is a well-documented risk factor associated with some child molesters.

Developmental influences. Recognition of the multiple factors that determine child molestation has led clinicians and investigators to examine the antecedent and concurrent experiences that place sexual abuse in a developmental context. One variable, "caregiver inconstancy," measures the frequency of changes in primary caregivers and the longest time spent with any single caregiver; it reflects the permanence and consistency of the child's interpersonal relationships with significant adults. Caregiver inconstancy, a powerful predictor of the degree of sexual violence expressed in adulthood,⁹ interferes with the development of long-term supportive relationships, increasing the likelihood of an attachment disorder. Attachment disorders may be characterized by intense anxiety, distrust of others, insecurity, dysfunctional anger, and failure to develop normal age-appropriate social skills. Thus, specifiable early childhood experiences may lead to interpersonal deficits and low self-esteem that severely undermine development of secure adult relationships. Individuals having these interpersonal and social shortcomings are more likely than others to turn to children to meet their psychosexual needs.

Section 2. Typology and Treatment

Classification of Child Molesters

Diagnosis and assessment. Just as the childhood and developmental experiences, adult competencies, and criminal histories of child molesters differ considerably, so do the motives that underlie the behavior patterns that characterize their sexual abuse of children. Thus, informed decisions about these offenders require some understanding of the dimensions believed to be important in discriminating among them. Diagnosis aims to reduce this diversity by assigning the offender to a class or group of individuals with similar relevant characteristics. Identifying and measuring these relevant characteristics is the task of assessment.

A reliable, valid classification system can improve the accuracy of decisions (1) in the criminal justice system (where dangerousness and reoffense risk are assessed and resources are allocated), (2) in the clinical setting (where a more informed understanding of particular classes of offenders can be used to optimize treatment plans), and (3) in the design of more effective primary prevention strategies. A classification model may also help in deciphering critical antecedent factors that contribute to different outcomes (i.e., different “types” of child molesters).

DSM-IV classification. The 1994 edition of the *Diagnostic and Statistics Manual of Mental Disorders (DSM-IV)* places pedophilia under the heading, “Sexuality and Gender Identity Disorders.”¹⁰ According to *DSM-IV*, the onset of pedophilia “usually begins in adolescence,” and its course is “usually chronic.” Specific behavioral criteria for diagnosing pedophilia are listed, as follows:

- The subject has experienced, for at least 6 months, recurrent intense sexual urges or fantasies involving sexual activity with a prepubescent child (age 13 or younger).
- The subject has acted on these urges or is markedly distressed by them.

- The subject is at least 16 years old and at least 5 years older than the victim. (Late adolescent subjects who are involved in ongoing relationships with 12- or 13-year-old youngsters are excluded.)

Three other specifications figure in this classification system: (1) whether the client is sexually attracted to males, females, or both; (2) whether the offenses are limited to incest; and (3) whether the client is an “exclusive” (attracted only to children) or “nonexclusive” type.

Although the *DSM-IV* classification system may succeed in isolating the “pedophilic” child molester, it fails to capture those incest and extrafamilial offenders without known 6-month histories of sexualized interest in children. Requiring evidence that an individual has met the first (and critical) diagnostic criterion dealing with “recurrent intense sexual urges or fantasies” involving children will inevitably screen out a large number of child molesters.

Sex-of-victim model. Classification of child molesters on the basis of their victims’ sex—same-sex, opposite-sex, or mixed-group offenders—has shown stability over time.¹¹ In addition, it has demonstrated predictive validity as well as some concurrent validity (e.g., it corresponds as expected with penile plethysmographic responsiveness to stimuli depicting specific ages and sexes).¹² Many reports have suggested that, among extrafamilial offenders, same-sex child molesters are at highest risk to reoffend and opposite-sex child molesters are at lowest risk. However, the sex-of-victim distinction has not received consistent support. In contrast to the typical finding, at least four recent studies found either no differences in recidivism rates among groups or differences that were opposite to prediction.¹³

The reasons for discrepant findings based on the sex-of-victim distinction are unclear, although several possibilities come immediately to mind:

- The large number of unreported sexual assaults on children.

- Possible biases against reporting homosexual encounters.
- Situational factors that might lead to assaults on the less-preferred sex.
- Incarceration after a single assault.

Further, some studies do not distinguish between incest offenders, who are almost exclusively heterosexual in their choice of victims, and nonincest offenders. Assuming that “true” incest offenders (that is, those whose offenses are exclusively intrafamilial) constitute a clinically and theoretically meaningful group of child molesters, the proportion of such cases in any particular sample might affect the differences found between same- and opposite-sex offenders.

Clinically derived multidimensional systems. In the earliest taxonomic systems for child molesters, which were based exclusively on clinical experience, three subtypes consistently appeared:

- Offender with an exclusive and longstanding sexual and social preference for children (Common Type 1).
- Offender whose offenses are seen as a shift or regression from a higher, adult level of psychosexual adaptation, typically in response to stress (Common Type 2).
- Offender who is a psychopath or sociopath with very poor social skills and who turns to children largely because they are easy to exploit—not because they are preferred or even desired partners (Common Type 3).

The most historically important of these hypothetical subtypes are the “fixated” and the “regressed” (Common Types 1 and 2, respectively). Implicit or explicit in the various systems that attempted to define fixated and regressed types was an assessment of achieved level of social competence. In addition to being described as having more intense pedophilic interest, fixated offenders were also typically differentiated from regressed offenders by marital status, number and quality of age-appropriate heterosexual relationships, and achieved educational

and occupational levels. The fixated child molester was hypothesized to have a negligible history of dating or peer interaction in adolescence and adulthood, and, if married, the quality of his relationship was considered to be poor.

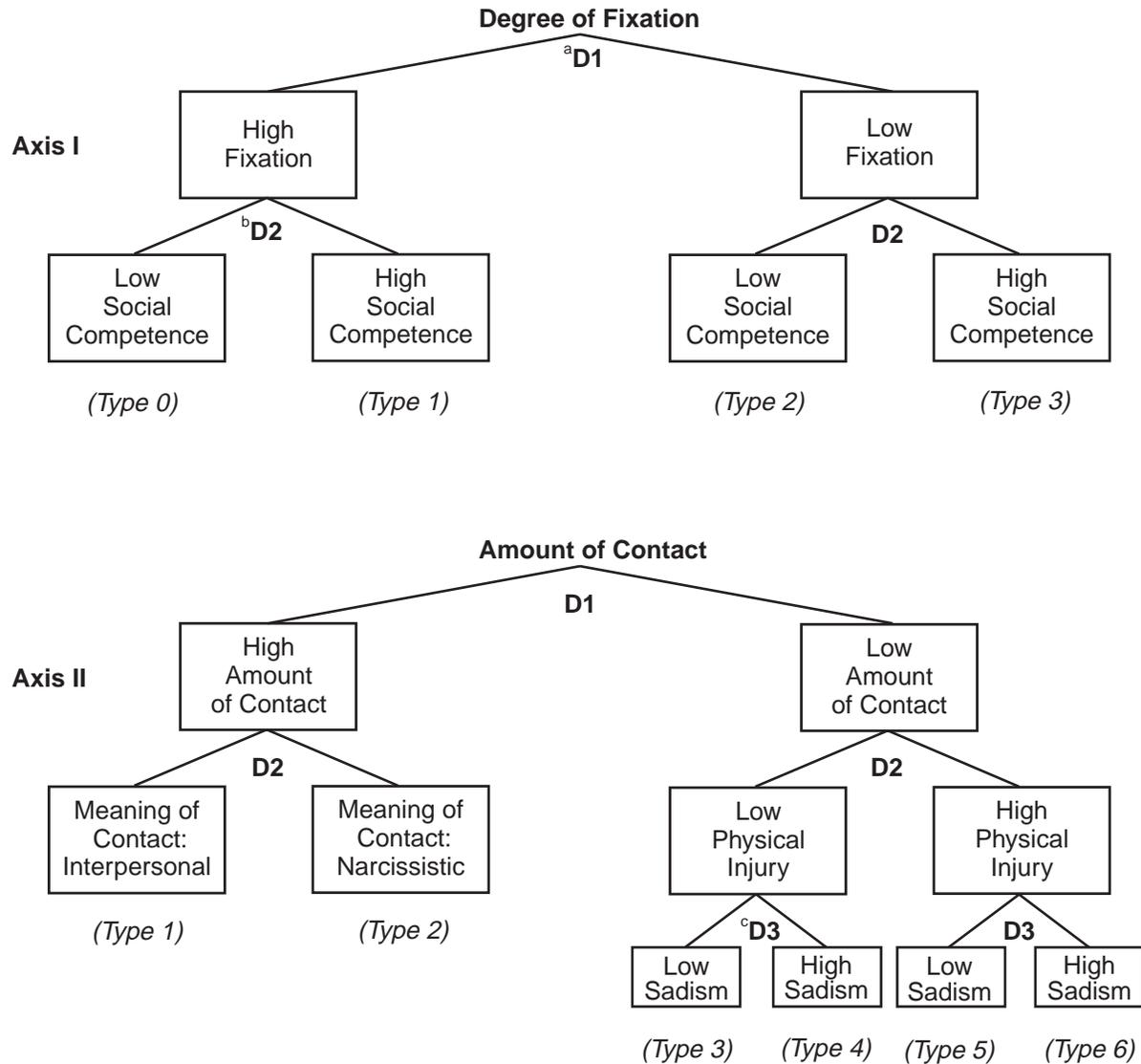
Regressed offenders, in contrast, were described as more likely to have been married and to have developed appropriate heterosexual relationships prior to their “regressive” sexual offenses. Thus, the construct of social competence was clearly involved in the distinction between fixated and regressed types, but, when empirically tested,¹⁴ this distinction was found to be flawed. Results showed that the two groups were not homogeneous. Indeed, social and interpersonal competence were found to be independent of fixation.¹⁵

The MTC:CM3 model. To meet the need for a clearly operationalized, reliable, valid taxonomic system for child molesters, researchers at the Massachusetts Treatment Center (MTC) for Sexually Dangerous Persons developed MTC:CM3, a two-axis typology (see exhibit 1). On Axis 1, fixation and social competence are completely independent dimensions, and each has distinct developmental antecedents and adult adaptations.¹⁶ The concept of regression was dropped in developing MTC:CM3, and a newly defined fixation dimension (i.e., “intensity of pedophilic interest”) was crossed with a dimension of social competence, yielding four independent types:

- High fixation, low social competence (Type 0).
- High fixation, high social competence (Type 1).
- Low fixation, low social competence (Type 2).
- Low fixation, high social competence (Type 3).

A new behavioral dimension (“amount of contact with children”) was added on a separate coordinate (Axis II) and became a powerful discriminator with respect to reoffense risk. In addition, the degree of violence employed by an offender was differentiated into dimensions of physical injury (high/low) and sadism (present/absent), yielding six distinct Axis II subtypes whose hypothetical characteristics

Exhibit 1. Flow Design of the Decision Process for Classifying Child Molesters on Axis I and Axis II of MTC:CM3



^a**D1** Decision 1

^b**D2** Decision 2

^c**D3** Decision 3

Exhibit 2. Hypothetical Profiles of MTC:CM3 Axis II Types

	Interpersonal (Type 1)	Narcissistic (Type 2)	Exploitative (Type 3)	Muted Sadistic (Type 4)	Nonsadistic Aggressive (Type 5)	Sadistic (Type 6)
Amount of Contact With Children	High	High	Low	Low	Low	Low
Sexual Acts	Fondling, Caressing, Frottage, (Non-phallic sex)	Phallic Non- sadistic sex	Phallic Non- sadistic sex	Sodomy “Sham” sadism ^a	Phallic Non- sadistic sex	Sadism
Relationship of Offender to Victim	Known	Known or Stranger	Stranger	Stranger	Stranger	Stranger
Amount of Physical Injury to Victim	Low	Low	Instru- mental ^b	Instru- mental ^b	High	High
Amount of Planning in Offenses	High ^c	Moderate	Low	Moderate	Low	High

^a “Sham” sadism implies behaviors or reported fantasies that reflect sadism without the high victim injury present in Type 6.

^b Instrumental aggression implies only enough force to gain victim compliance.

^c Interpersonal types know their victims and may spend a considerable amount of time “grooming” them (setting them up), but the offenses often appear to be unplanned or spontaneous.

are shown in exhibit 2. Exclusive incest offenders were omitted in the design of MTC:CM3; including such offenders in this system would require considerable reconceptualization and revision. Although further revision of MTC:CM3, including integration of Axis I (fixation and social competence) and Axis II (amount of contact with children, degree of injury to victim, and sadism), is necessary, validity studies conducted thus far clearly support the primary structural changes in this model.¹⁷

Course and prognosis among child molesters.

Among child molesters, both the course (progression of symptoms associated with the condition) and the prognosis (forecast of the probable course and likelihood of recovery) vary considerably. For example, onset ranges from early adolescence to middle adulthood (as in the case of some exclusive incest offenders), and the prognosis ranges from cases of lifelong, intractable pedophilic interest that is resistant to treatment to isolated instances of incest in adults with a sexual preference for peers, ample remorse and victim empathy, and a high likelihood of “recovery.”

Clinical Management of Offenders

Treatment. Over the past decade, the provision of therapeutic services for sex offenders has increased significantly. A 1994 survey reported 710 adult and 684 juvenile treatment programs,¹⁸ up from 1985 survey results that showed 297 adult and 346 juvenile treatment programs.¹⁹ Broadly speaking, sex offender treatment programs employ four approaches:

- Evocative therapy, which focuses on (1) helping offenders to understand the causes and motivations leading to sexually deviant and coercive behavior and (2) increasing their empathy for the victims of sexual assault. This approach may include individual, group, couples/marital, and family therapy. Group therapy may be eclectic or issue focused (i.e., specialty groups may target substance abuse, adult children of alcoholics, victim empathy, victim survivors, social skills/assertiveness training, black awareness, gay identity, or Vietnam veterans).
- Cognitive behavior therapy, which focuses on sexual assault cycles and techniques that interrupt those cycles; altering the beliefs, fantasies, and rationalizations that justify and perpetuate sexually aggressive behavior; and controlling and managing anger. Studies of relapse prevention, the most commonly employed cognitive behavioral model, report that, for child molesters, the most frequently identified experiences prior to committing an offense were planning the offense (73 percent of sample) and low victim empathy (71 percent of sample).²⁰
- Psychoeducation groups or classes, which use a more didactic approach to remedy deficits in social and interpersonal skills; they teach anger management techniques, principles of relapse prevention, and a range of topics that includes human sexuality, dating and communication skills, and myths about sexuality and relationships.
- Pharmacological treatment, which focuses on reducing sexual arousability and the frequency of deviant sexual fantasies through the use of antiandrogen and antidepressant medication.

These approaches are not mutually exclusive, and the ideal treatment program (yet to be identified) would employ combinations of them. State-of-the-art intervention at this point (cognitive behavior therapy and, when appropriate, medication) can effectively reduce reoffense rates. For example, recidivism rates for new sexual offenses by child molesters treated under the cognitive behavior therapy model, with a focus on relapse prevention, were 4.6 percent in a 3-year followup study²¹ and 3 percent in a 6-year followup study.²² The nonvolunteer control group in the 3-year followup had a sexual recidivism rate of 8.2 percent, yielding an apparent treatment effect of 3.6 percent.

When these failure rates are compared to those for Years 3 and 5 in the MTC study (see exhibit 6, “Cumulative Failure Rates for Sexual Offenses Within Nine Time Gates,” in section 4) of sex offenders who did not receive cognitive-behavior therapy, the presumptive effectiveness of treatment in reducing the probability of sexual reoffense is between 7 and 15 percent. A recent meta-analysis of 12 sex offender treatment studies (N = 1,313) found that the overall recidivism rate for untreated sex offenders was 27 percent, while for treated offenders it was 19 percent—an apparent treatment effect of 8 percent.²³ These statistics suggest that treatment can reduce child molester recidivism. The wide variability in study findings on reoffense rates of both treated and untreated offenders, however, makes efforts to find optimal treatment interventions as problematic as those to assess and predict recidivism.

Community-based maintenance and control.

The vast majority of sex offenders are released eventually. Thus, community-based clinical management and control of child molesters are indispensable parts of any rehabilitation program if public safety is to be ensured. An effective

community-based maintenance program for child molesters should include the following components:

- Coordination by highly trained and well-supervised parole agents and probation officers who carry small caseloads (15 to 20 offenders) to ensure intensive surveillance/supervision.
- Mandatory treatment by therapists trained and supervised in cognitive behavioral theory with sex offenders; this is especially critical for adjustment and maintenance.
- Evaluation for medication.
- Proper monitoring and supervision of vocational, social, recreational, and leisure activities.
- Confidential notification of local police departments and/or the district attorney's office.

Registration with the criminal justice system is a widely practiced, reasonable procedure that should be considered a part of an offender's aftercare plan. Community notification, however, is an untested management technique—that has at least as many potential problems as benefits—and *must* be empirically evaluated. Indeed, the general notification of laypersons outside the criminal justice system may increase, rather than decrease, the risk of recidivism by placing extreme pressure on the offender; examples of stressors include threats of bodily harm, termination of employment, on-the-job harassment, and forced instability of residence.

Continuity of treatment is considered a critical factor in managing sex offenders. Maintenance is forever, and relapse prevention never ends. Community-based clinical management must be supportive, vigilant, and informed by current wisdom about maximally effective maintenance strategies.

Section 3. Reoffense Risk

Dispositional Decisions

Recidivism rates are highly variable, making it impossible to draw any reliable conclusions about reoffense among child molesters as a group. Most recent studies have been conducted in order to evaluate treatment efficacy; consequently, little is known about recidivism independent of some treatment intervention. Moreover, variations in recidivism rates associated with different treatment programs are difficult to interpret. Recidivism rates across studies are confounded by differences in the statutes and sentencing and parole guidelines among jurisdictions, duration of exposure (i.e., time in the community, where the child molester is at liberty to reoffend), offender characteristics, treatment-related variables (including differential attrition rates, program integrity, and amount of treatment), amount and quality of posttreatment supervision, and many other factors.

The criminal justice system is responsible for certain discretionary decisions concerning sex offenders, most of which rest on a presumption about an individual offender's dangerousness or reoffense risk. Examples of decisions driven by underlying assumptions about the probability of recidivism include:

- Whether to leave an offender in the community on probation.
- Whether to parole an offender and, if so, the level/duration of supervision needed.
- Whether to recommend compulsory treatment.
- Whether to require registration with the police.
- Whether to notify the community.

From a forensic standpoint, potential dangerousness is a question central to the disposition of sex offenders. Yet there is no reliable body of empirically derived data that can inform and guide decisionmaking about reoffense risk—primarily

because of methodological differences in existing studies (see section 4).

Predictors of Sexual Recidivism

Although ample evidence exists to demonstrate the predictive superiority of statistical (actuarial) risk assessment methods over clinical judgment, few concerted efforts have been made to develop and empirically test actuarial prediction devices for sexual offenders. The one obvious exception is the work of investigators in Canada, who have focused on psychopathy, measures of prior criminal history, and phallometric assessment to predict sexual recidivism.²⁴ A recent study on risk assessment among extrafamilial child molesters included three of the dimensions used in MTC:CM3 (fixation, social competence, and amount of contact with children). Study researchers argued that the MTC:CM3 assessment of fixation—a behavioral measure of the strength of an offender's pedophilic interest—may serve as a viable substitute for phallometry, which is intrusive and much more expensive.²⁵

Risk assessment study of extrafamilial offenders.

The predictive value of a rationally derived composite of variables for assessing reoffense risk, based on archival data (prison and criminal records), was tested in a followup study of extrafamilial child molesters who had been discharged from the Massachusetts Treatment Center over a period of 25 years. The sample of 111 represents 96.5 percent (N=115) of all child molesters discharged between 1960 and 1984.

Data reveal differential predictive accuracy depending on the type of criminal behavior being examined. Three variables—degree of sexual preoccupation with children (fixation), paraphilias (fetishism, transvestism, and promiscuity), and number of prior sexual offenses predicted *sexual* recidivism, while those variables that reflect impulsive, antisocial behavior predicted recidivism for *nonsexual crimes involving physical contact with a victim* and *violent* (sexual and nonsexual) *crimes*.

Unlike other recent studies,²⁶ this study found no evidence for the utility of alcohol history, social competence, and sex of child-victim as predictors of reoffense. In the case of victim sex, one explanation for these inconsistencies may be due to sampling differences. The sample of child molesters examined in this study had an average of three known sexual offenses prior to release. This sample had a higher base rate probability of reoffense than would likely be observed in an unscreened sample of child molesters recruited from the general prison population. Among child molesters who are at higher risk to reoffend, the victim's sex may be less important to accurate prediction than such factors as degree of sexual preoccupation with children and impulsivity.

Predictive accuracy. The variables associated with reoffense risk among child molesters that were examined for discriminant validity had reasonable predictive accuracy with regard to both sexual and nonsexual reoffending; overall predictive accuracy was approximately 75 percent. The results of this study are sample-specific and may not be generalizable. The potential uniqueness of this sample is suggested by the study's failure to find any predictive efficacy for the victim-sex variable.

Although risk assessment procedures that rely exclusively on archival data may never achieve the efficiency of much more time-intensive procedures, such as the penile plethysmograph or a comprehensive interview that assesses psychopathy (e.g., *The Hare Psychopathy Checklist-Revised, PCL-R*),²⁷ the distinct advantages of an archival scale include its ease of use (i.e., it does not require the compliance or even the presence of the offender), cost efficiency, and relatively high reliability. Despite these presumptive advantages, the ability of such an archival based procedure to reasonably discriminate across samples remains to be demonstrated.

Section 4. Variability in Child Molester Recidivism

The literature on sex offenders shows considerable variability in estimates of recidivism rates. A major reason for this variability, which affects what is known about the career patterns of sex offenders, has to do with differences in the definition of “reoffense,” in the type of criminal offense indexed, and in the length of the exposure period being considered. For example, if recidivism is measured by an *arrest for any offense* within a 2-year period, the frequency of recidivism will be higher than if recidivism is measured by a new *conviction (or incarceration) for a sexual offense* during the same timeframe.

Recidivism rates are typically reported as simple percentages of offenders known to have reoffended during some finite followup period, such as 2 years. This measurement underestimates recidivism because it considers only those known to have reoffended during the study period; it does not take into account each offender’s “window of opportunity” for reoffense (i.e. exposure time, or the amount of time each offender has been on the street and able to reoffend). It stands to reason that someone who has been in the community for 6 months has had much less opportunity to reoffend than someone who has been in the community for 10 years.

For example, if a 10-year followup of 100 offenders reveals that 15 men reoffended, the estimated recidivism rate based on the percentage of those who recommitted an offense would be 15 percent. This figure (15 percent) implies, however, that all 100 men were on the street for 10 years and therefore had an equal opportunity to reoffend. In reality, these 100 men had different discharge dates. Many were not on the street for the full 10 years, and some are likely to reoffend after the followup study has been concluded.

Survival Analysis

Underestimations resulting from the use of simple percentages can be addressed by using survival

analysis, which considers both the commission of subsequent crimes and the length of time between release and criminal activity. In survival analysis, recidivism is reported as a “failure rate” over time. Moreover, survival analysis allows one to include in a single analysis all offenders in the sample (those followed until they reoffended and those followed for the duration of the study without reoffending). Thus, survival analysis yields a statistical summary of all cases regardless of the length of time each was followed and whether or not a reoffense was committed during the study period.

To illustrate the variability in estimated recidivism, researchers used a data set on 251 repetitive sex offenders (136 rapists and 115 child molesters) released over a 25-year period from the Massachusetts Treatment Center (MTC) for Sexually Dangerous Persons. Only the data on child molesters are presented here. Using simple percentages and survival analysis, this information was examined from three measurement perspectives:²⁸

- By categories of criminal offense (sexual or not, involving physical contact with a victim or not).
- By criminal offense dispositions (i.e., charge, conviction, or incarceration). In general, analyses of charges or arrests provide the highest estimates of recidivism, and those that examine conviction or incarceration yield the lowest estimates.
- By exposure time. As noted, the more time spent on the street, the greater the opportunity to fail (reoffend).

Disposition of sexual offenders. Exhibit 3 shows, by offense type and disposition, the percentage of actual reoffenses during the study period, the average exposure time before reoffense, and the estimate of recidivism based on survival analysis (referred to as failure rate). Exhibit 4 shows the survival curve, i.e., the estimated probability that child molesters would “survive” in the community without being charged, convicted, or imprisoned for a *sexual* offense over the 25-year study period.

Exhibit 3. Variability in Child Molester Recidivism by Offense Type and Disposition

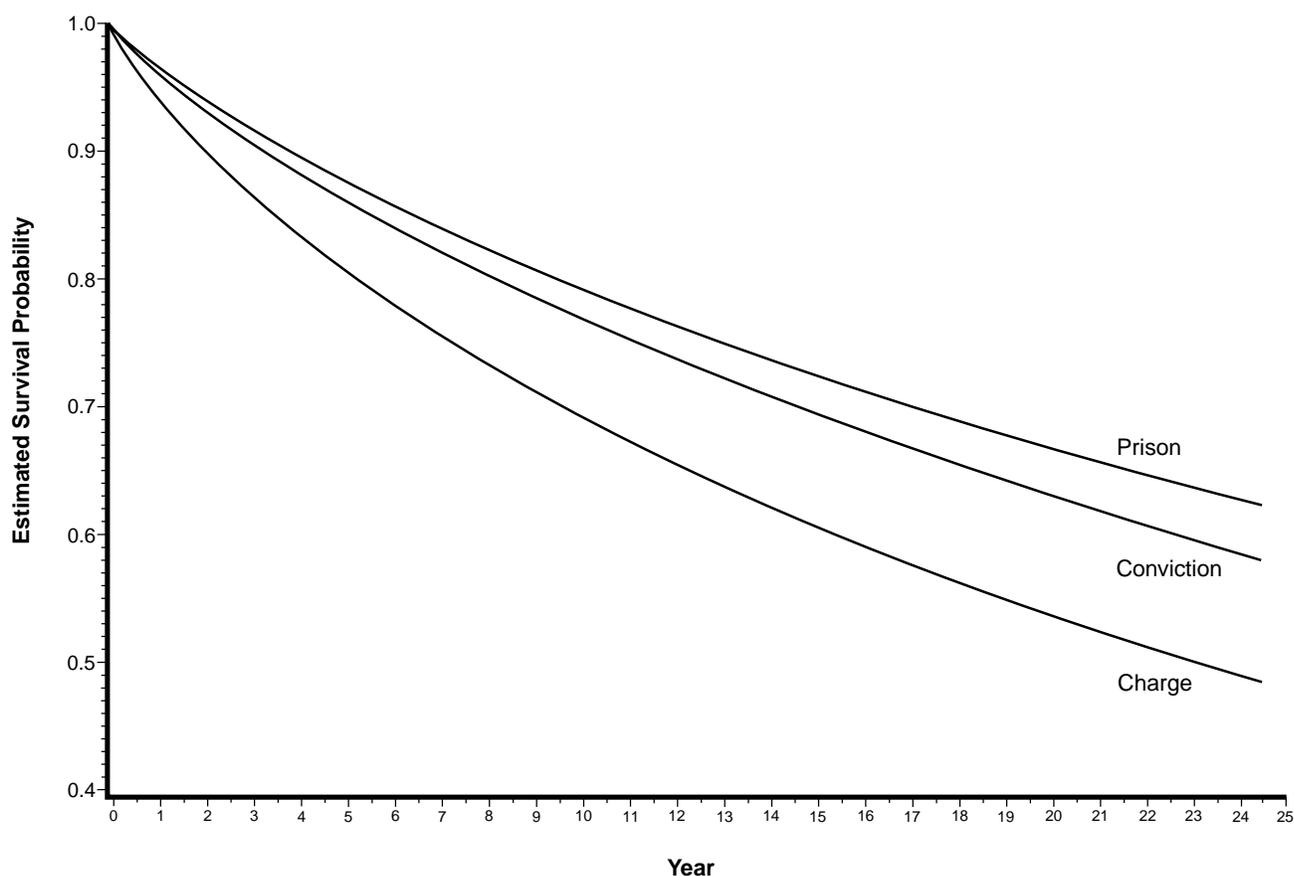
Disposition	Criminal Activity			
	Sexual Victim-Involved	Nonsexual Victim-Involved	Nonsexual Victimless ^b	Composite (any offense)
Charge				
Percentage of sample who reoffended	32%	14%	30%	54%
Average exposure time ^a before reoffense	3.64 yrs	5.58 yrs	3.90 yrs	2.75 yrs
Failure rate at 25 years	52%	23%	48%	75%
Conviction				
Percentage of sample who reoffended	25%	6%	12%	39%
Average exposure time ^a before reoffense	3.98 yrs	7.05 yrs	5.28 yrs	3.45 yrs
Failure rate at 25 years	41%	10%	22%	56%
Imprisonment				
Percentage of sample who reoffended	23%	4%	6%	30%
Average exposure time ^a before reoffense	4.17 yrs	8.50 yrs	6.78 yrs	3.92 yrs
Failure rate at 25 years	37%	7%	21%	44%

Child molesters, N = 115

^a Time in the community, where the opportunity exists to reoffend.

^b An offense that involved no physical contact with a victim.

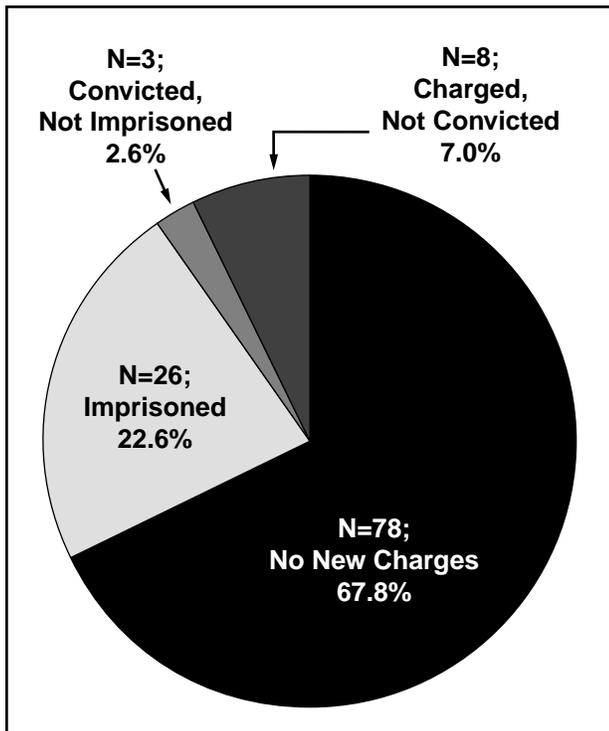
Exhibit 4. Child Molester Survival Curves for Different Dispositions of Sexual Charges



Of the 115 child molesters, 78 apparently received no new charges for a *sexual* offense during the study period. Of the remaining 37 offenders, 8 were charged but never convicted, 3 were convicted but not imprisoned, and 26 were convicted and imprisoned (see exhibit 5). The corresponding percentages, with failure rates in parentheses, were 32 percent (52 percent) for charges, 25 percent (41 percent) for convictions, and 23 percent (37 percent) for incarcerations. Underestimation of sexual reoffending, as a result of using the simple percentage, was similar for all three dispositional categories (38 percent for charges, 39 percent for convictions, and 38 percent for imprisonments).

Exposure time. Nine separate time periods (or time gates) over the 25-year study period were examined (see exhibit 6). The increments in cumulative failure rates for new sexual charges are 4 percent per year through Year 3, dropping to 3 percent in Year 4 and 2 percent in Year 5. After Year 5, the charge rate continues to increase at noteworthy increments: 11 percent between Year 5 and Year 10, 9 percent between Year 10 and Year 15, 7 percent between Year 15 and Year 20, and 6 percent between Year 20 and Year 25. It is significant—and should be underscored—that, 10 years after discharge, there was a substantial reoffense rate (i.e., at Year 10, the recidivism rate for new

Exhibit 5. Child Molesters Charged With, Convicted of, or Imprisoned for a New Sexual Offense



sexual charges was 30 percent, and by Year 25, it had increased to 52 percent). Contrary to conventional wisdom, most reoffenses do not occur within the first several years after release; child molesters in this sample reoffended as late as 20 years following release.

If followup had been restricted to the conventional exposure period of 12 to 24 months, approximately 40 to 45 percent of new sexual charges would have been missed; if followup had been extended to 60 months, 30 percent of new sexual charges would still have been missed. The rate of recidivism using conviction or incarceration ranged from 64 to 80 percent of the rate using charge throughout the study period. By the end of 25 years, the conviction and incarceration rates were 41 percent and 37 percent, respectively, compared to the charge rate of 52 percent (see exhibit 7).

Disposition of all offenses. Examination of cumulative failure rates for *any* new offense revealed a steady increase in charges throughout the followup period, with an initial rate of 14 percent, increasing to 37 percent at Year 5 and 75 percent at Year 25. The gap between the charge and conviction rates increased steadily, from 6 percent in Year 1, to 14 percent by Year 5, to 17 percent by Year 10, to 18 percent throughout the remainder of the study. The gap between conviction and incarceration rates also grew consistently: from 2 percent in Year 1, to 5 percent at Year 5, to 12 percent by the end of the study period.

Implications

The study reported here addresses the high variability in sex offender recidivism estimates by examining several of the critical methodological differences that underlie this variability. These include the index criminal offense examined (sexual or nonsexual, physical contact or no physical contact with a victim), the dispositional definition of reoffense used (arrest, charge, conviction, or incarceration), and the length of exposure time considered (simple percentage of crimes committed during the study period or survival analysis of time-to-reoffense outcomes).

Because reoffense risk is the primary basis for sentencing and parole decisions on a convicted offender's dangerousness, the methodological inconsistencies of existing studies on child molester recidivism make it impossible to reach informed and judicious conclusions in this regard. Standardized, empirically corroborated risk assessment conditions and procedures are urgently needed to enable those making forensic decisions about child molesters—as well as the attorneys, probation and parole officers, and clinicians who service this group of offenders—to proceed with confidence in the reliability of data and associated assumptions about recidivism.

Conclusion

Sexual offenders constitute the one category of dangerous criminals most subject to either special

Exhibit 6. Cumulative Failure Rates for Sexual Offenses Within Nine Time Gates

Disposition	Followup Year								
	1	2	3	4	5	10	15	20	25
Charge	.06	.10	.14	.17	.19	.30	.39	.46	.52
Conviction	.04	.07	.10	.12	.14	.23	.31	.37	.41
Prison	.04	.07	.09	.11	.13	.21	.28	.33	.37

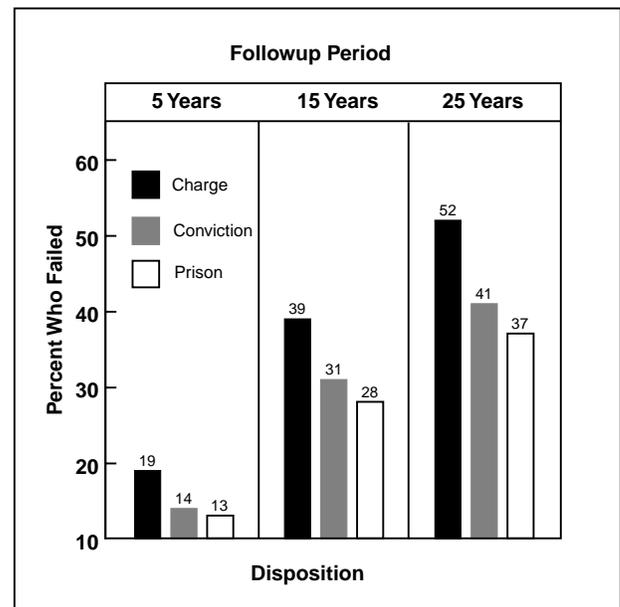
commitment statutes or ad hoc discretionary and dispositional decisions. These laws and the decisions that they require are often based on assumptions about sex offenders that are, at best, misleading and, at worst, erroneous. Given the serious concerns about sex offenders within the criminal justice system and society at large, the need for valid diagnostic and assessment tools is urgent. Indeed, the most formidable task is to develop empirically corroborated estimates of sexual reoffense probabilities for different subgroups of sex offenders under standardized operational conditions.

Practitioners, researchers, and legislators should be guided by moderation, clear vision, and empirical evidence. Over the years, many laws governing sex offenders have been enacted and later repealed.²⁹ Two timely examples of presumably well-intentioned but problematic legislation are the much-discussed community notification laws and the new California law requiring repeat sex offenders to choose between “chemical castration” (i.e., treatment with antiandrogenic medication) or surgical castration. The California statute poses difficulties on several counts:

- From an ethical standpoint, mandating either an intrusive, irreversible surgical procedure or treatment with a drug that the U.S. Food and Drug Administration has not approved for use with sex offenders is highly questionable.

- From a practical standpoint, sex offenders cannot be relied on to comply with a drug regimen to which they have not consented and from which they cannot withdraw. Moreover, the apparently compliant offender can easily circumvent the effects of the drugs or the surgery by buying testosterone (steroids) on the street.

Exhibit 7. Sexual Recidivism of Child Molesters by Disposition and Length of Followup



- From an empirical standpoint, the law makes the invalid assumption that all sex offenders are motivated by uncontrollable sexual urges. Chemical reduction of testosterone is appropriate for some, but not all, child molesters; when medication is used, it must be included as one component of a treatment plan that includes therapy. It is critical to keep in mind, however, that surgical or chemical reduction of testosterone will not, by itself, solve the problem of child molestation.

Reducing the risk of recidivism among sex offenders is a problem for which no easy answers or shortcuts exist. Treatment provided in prison must be continued after offenders are released into the community. Reintegration is especially problematic for child molesters. Detailed aftercare plans, orchestrated by well-trained and supervised parole agents and probation officers, are essential to reducing reoffense risk and should include consideration of the vocational, psychotherapeutic, pharmacological, social, and recreational needs of the offender.

Clearly, the most compelling motive for treating child molesters is the reduction in victimization rates that is presumed to result. Society resists treating sexual offenders, however, because to do so is perceived as a humane response to intolerable behavior. If treatment can be demonstrated to reduce the probability of reoffense, then working on the development and refinement of treatment methods and procedures is an essential secondary intervention.

The criminal justice community faces difficult, but not insuperable, challenges as it moves to balance the right of the community to be protected with the rights of offenders. If those professionals who deal with the victims and perpetrators of child molestation are willing to harness their collective energy, pull in a common direction, and speak with a single firm voice, properly informed laws can be enacted that will better control child molesters and make communities safer for children.

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