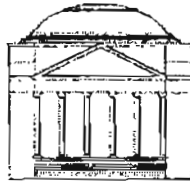


Juvenile Justice Fact Sheet

**UNDERSTANDING JUVENILE SEX OFFENDERS:
RESEARCH FINDINGS AND GUIDELINES FOR
EFFECTIVE MANAGEMENT AND TREATMENT**

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INCIDENCE AND DEMOGRAPHIC CHARACTERISTICS

Juvenile perpetrated sexual aggression has been a problem of growing concern in American society over the past decade. Currently it is estimated that juveniles account for up to one-fifth of the rapes,¹ and one-half of the cases of child molestation² committed in the United States each year. The majority of cases of juvenile sexual aggression appear to involve adolescent male perpetrators,³ however, a number of clinical studies have pointed to the presence of females and prepubescent youths, who have engaged in sexually abusive behaviors. Juvenile sexual offending appears to traverse racial and cultural boundaries.

¹ In 1995 juveniles were involved in 15% of all forcible rapes cleared by arrest; approximately 18 juveniles per 100,000 (ages 10 to 17) were arrested for forcible rape in 1995. This latter number is approximately 6 times higher than the figure for Canada.

² Approximately 16,100 juveniles were arrested for sexual offenses in 1995 (excluding rape and prostitution). This is approximately 3 times the number of youths arrested for forcible rape.

³ Adolescents (ages 13-17) accounted for approximately 89% of juvenile forcible rape arrests, and 82% of the other juvenile sex offense arrests, in 1995.

Causes and Patterns of Juvenile Sex Offending

A number of etiological factors (casual influences) have been identified that are believed to help explain the developmental origin of juvenile sex offending. Factors that have received the most attention to date include: maltreatment experiences, exposure to pornography, substance abuse, and exposure to aggressive role models.

While sexual aggression may emerge early in the developmental process, there is no compelling evidence to suggest that the majority of juvenile sex offenders are likely to become adult sex offenders. The estimated risk of juvenile sex offending leading to adult offending may have been exaggerated by an over-reliance on retrospective research studies.⁴ Existent longitudinal studies suggest that aggressive behavior in youths is not always continuous, and that juveniles who engage in sexual aggression frequently cease such behavior by the time they reach adulthood.

CLINICAL CHARACTERISTICS AND JUVENILE SEX OFFENDER SUBTYPES

Juvenile male sex offenders vary on a number of clinical and criminal indicators. As with their adult counterparts, juvenile sex offenders appear to fall primarily into two major types: those who target children, and those who offend against peers or adults. The distinction between these two groups is usually based on the age difference between the victim and the offender.⁵

Juvenile Offenders Who Sexually Offend Against Peers or Adults

- Juveniles who sexually offend against peers or adults predominantly assault females and strangers or casual acquaintances.
- The sexual assaults of these youths are more likely to occur in association with other types of criminal activity (e.g., burglary) than are the assaults of those who target children.
- These juvenile sex offenders are more likely to have histories of non-sexual criminal offenses, and appear more generally delinquent and conduct disordered than those who sexually assault children.
- This group of youthful offenders is also more likely to commit their offenses in public areas than those who offend against children.
- These juveniles generally display higher levels of aggression and violence in the commission of their sexual crimes than those who offend against children.
- Youths who sexually offend against peers or adults are more likely to use weapons and to cause injuries to their victims than those who sexually assault children.

⁴ Retrospective research may exaggerate the strength of correlations. Longitudinal research, or the prospective tracking of individuals, typically provides a more accurate index of event likelihood.

⁵ Child offenders are those who target children five or more years younger than themselves.

Juvenile Offenders Who Sexually Offend Against Children

- Juveniles who sexually offend against children have both a higher number of male victims and victims to whom they are related than peer/adult offenders.
- Although females are victimized at slightly higher rates than males, almost 50% of this group of juvenile sex offenders has at least one male victim.
- As many as 40% of their victims are either siblings or other relatives.
- The sexual crimes of juvenile child molesters tend to reflect a greater reliance on opportunity and guile than injurious force. This appears to be particularly true when their victim is related to them. These youths may “trick” the child into complying with the molestation, use bribes, or threaten the child with loss of the relationship.
- Within the overall population of juveniles who sexually assault children, there are certain youths who display high levels of aggression and violence. Generally, these are youths who display more severe levels of personality and/or psychosexual disturbances (e.g., psychopathy; sexual sadism, etc.).
- Juveniles who sexually offend against children have often been characterized as suffering from deficits in self-esteem and social competency.⁶
- Many of these youths, particularly those with victimization histories, show evidence of depression. Although the ability of these juveniles to form and maintain healthy peer relationships and successfully resolve interpersonal conflicts may be impaired, they generally evidence less emotional indifference to the needs of others than peer/adult offenders.

Characteristics Common to Both Groups of Juvenile Sex Offenders

Juveniles who sexually assault children, and those who target peers or adults, share certain common characteristics. These include:

- High rates of learning disabilities and academic dysfunction (30-60%).
- The presence of other behavioral health problems, including substance abuse, and disorders of conduct (up to 80% have some diagnosable psychiatric disorder).
- Observed difficulties with impulse control and judgment.

THE AMENABILITY OF JUVENILE SEX OFFENDERS TO TREATMENT

While funding and ethical issues have made it difficult to conduct carefully controlled treatment outcome studies,⁷ a number of encouraging clinical reports on the treatment of juvenile sex offenders have been published. While these studies are not definitive, they provide empirical support for the belief that the majority of juvenile sex offenders are

⁶ Social competency is defined as possession of prerequisite skills/attributes necessary for forming and maintaining healthy interpersonal relationships. These include: social skills, leadership ability, and the ability to act assertively.

⁷ Controlled treatment outcome studies refer to those where treated juvenile sex offenders are compared to other groups of juveniles (e.g., non-treated juvenile sex offenders) on variables of interest (e.g., sexual recidivism rates).

amenable to treatment and achieve positive treatment outcomes.

In perhaps the best controlled study to date, Borduin, Henggeler, Blaske, and Stein (1990) compared "multisystemic" therapy⁸ (an intensive, multifaceted treatment targeting youth and family characteristics, peer relations, school factors, and neighborhood and community characteristics) with individual therapy in the outpatient treatment of sixteen adolescent sex offenders. Using re-arrest records as a measure of recidivism (sexual and non-sexual), the above two groups were compared at a three year follow-up interval. Results revealed that youths receiving multisystemic therapy had recidivism rates of 12.5% for sexual offenses and 25% for non-sexual offenses, while those youths receiving individual therapy had recidivism rates of 75% for sexual offenses and 50% for non-sexual offenses.

Program evaluation data suggest that the sexual recidivism rate for juveniles treated in specialized programs⁹ ranges from approximately 7%-13% over follow-up periods of two to five years. Studies suggest that rates of non-sexual recidivism are generally higher (25-50%). If findings from future treatment outcome studies on juvenile sex offenders parallel those on adult offenses, sexual recidivism rates will be higher in individuals who fail to successfully complete programs. In a recently conducted study, Hunter and Figueredo (1999) found that as many as 50% of youths entering a community-based treatment program were expelled during the first year of their participation. Program failure was found to be largely attributable to failure to comply with attendance requirements and/or therapeutic directives.¹⁰ Youths failing to comply with the program were found to have higher overall levels of sexual maladjustment (as measured on assessment instruments), and were judged possibly to be at greater long-term risk for sexual recidivism. In this study, lower levels of client denial at intake best predicted successful program compliance. Higher levels of denial were found in nonadjudicated youths.¹¹

LEGAL POLICY ISSUES

Legislative Trends

The rise in juvenile perpetrated violence over the past decade has resulted in legislation designed to enhance public safety, and raise the level of accountability of juveniles in the criminal justice system (see Hunter & Lexier, 1998 for a detailed discussion). Substantive changes were made in legal statutes or regulatory policy in more than 90% of the

⁸ Multisystemic therapy assumes that behavior problems are multidetermined and multidimensional, and "that interventions may need to focus on any one or combination of systems." Areas of therapeutic focus may include the following: cognitive processes, family relations, peer relations, and school performance. See Borduin, Henggeler, Blaske, and Stein, 1990, pp. 108-110 for more details.

⁹ "Specialized" programs are those that were specifically designed to treat juvenile sex offenders. See "Clinical Programming for Juvenile Sex Offenders" section for details of programming content.

¹⁰ An example of a therapeutic directive would be the writing of an "empathy letter" to the victim of the sexual abuse. See "Clinical Programming for Juvenile Sex Offenders" section.

¹¹ The above described studies pertain primarily to adolescent age male offenders. Presently, the National Center for Child Abuse and Neglect is funding two demonstration projects to evaluate treatment outcomes for pre-pubescent children with sexual behavior problems. The results of these studies should appear in the research literature in the near future.

states. This reform included changes related to the following:

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

The number of delinquency cases waived to the adult criminal courts increased by 71% between 1985 and 1994. The age at which juveniles may be tried as an adult has been lowered in over half of the states. Twenty jurisdictions have no minimum age restriction for trying a juvenile as an adult for certain serious crimes. Legislative changes have also made it more likely that once a juvenile is convicted of a crime in the adult courts, he will serve at least some minimum sentence. Presently, more than 50% of the states permit public access (with some age and offense restrictions) to juvenile court records. Eleven states permit public juvenile hearings with no age or crime restrictions.

Registration and Community Notification Laws

The registration and tracking of individuals convicted of sexual crimes involving violence or minors began with the passing of the Violent Crime Control and Law Enforcement Act of 1994. This act was amended in 1996, with the passing of "Megan's Law". This amendment required (as opposed to authorized) state and local law enforcement agencies to release information on individuals registered under the 1994 law deemed to be necessary for the maintenance of public safety. Criteria for mandatory lifetime sex offender registration, penalties for failure to register, and a requirement that sex offenders notify the FBI of changes in address, were stipulated in the Pam Lychner Sexual Offender Tracking and Identification Act of 1996. Federal guidelines specifically require the registering of juveniles when they have been convicted of rape, nonconsensual sexual perpetration or sodomy, or incest with a victim at least two years younger than themselves.

Virginia Code § 19.2-390.1 specifies that juveniles tried and convicted in the circuit courts for designated sexual offenses, including child molestation, be placed on the state sex offender registry. This registry is maintained by the Department of State Police. The State Police are required by law to notify the chief law-enforcement officer of the county, city or town of the locality listed as the person's address on the registration or re-registration and any person who has requested automatic notification pursuant to §19.2-390.2. The State police are also required by law to ensure that certain information on violent sex offenders be publicly available by means of the Internet. This information includes the individual's name, address, and photograph, and a brief description of the offense for which he was convicted.

PROMISING APPROACHES TO TREATMENT AND INTERVENTION

The number of programs providing treatment services to juvenile sex offenders more than doubled between 1986 and 1992, and has continued to climb. This growth in programming reflects both increased societal concern about rising rates of juvenile sexual

aggression, and the professional belief that early intervention may help stem the emergence of chronic patterns of sexual offending.

A review of issues believed to be important to the development of successful community-based treatment programming for juvenile sex offenders follows.

The Interface Between the Criminal Justice System and Treatment Providers

Most treatment specialists (see National Task Force on Juvenile Sexual Offending, 1993) are of the opinion that successful juvenile sex offender programming requires a coordination of effort between criminal justice system actors and providers. In order for juveniles to meaningfully participate in treatment programming, they must be willing to address their problems and comply with therapeutic directives. Adjudication and supervision typically prove to be useful tools in ensuring client accountability and compliance with treatment.

Clinical experience has shown that the suspension of the juvenile's sentence, contingent upon his successful completion of a treatment program, can be a particularly effective motivator. Under such collaborative arrangements with the courts, the treatment specialist provides ongoing progress reports to the court on the youth's participation in the program. Youths who fail to comply with program expectations can be brought back before the court for a dispositional review.

In many programs, probation officers play an integral role in assisting the treatment provider in addressing critical issues and in supervising the youth's activities in the home and community. The probation officer helps evaluate the extent to which the client is meaningfully participating in the treatment program and complying with court and therapeutic directives. He provides an additional link between the provider and the youth's family, and can assist the therapist(s) in impressing upon the family the importance of their involvement in the youth's rehabilitative programming.

The probation officer typically also provides a very important case management function. This includes analysis (sometimes along with the help of social services) of the appropriateness of the youth remaining in his home of origin during his participation in treatment, and his need for supplemental community programming (e.g., community service projects, etc.). As a case manager, the probation officer also facilitates appropriate communications between the treatment provider and other community agencies involved in the youth's overall care (e.g., school officials). In some programs, probation officers directly participate in the delivery of therapeutic services (e.g., co-therapist in a group). This most typically occurs in cases where the probation officer has received additional training in the treatment of sex offenders (see Association for the Treatment of Sexual Abuser reference for information on where such training can be received).

Assessment of Juvenile Sex Offenders for Community-Based Treatment

Critical to the success of community-based programming is the careful screening of all potential participants. Ideally, this review should reflect the careful consideration of issues related to dangerousness, severity of psychiatric and psychosexual disturbance, and amenability to treatment. The latter issues involve an assessment of the youth's level of accountability for his sexual offenses, his motivation for change, and his receptivity to

professional help.

It is preferable that these evaluations should be conducted by professionals who have documented clinical experience and training in working with the juvenile sex offender population. It is important that programs not compromise community safety by admitting highly aggressive and violent youth, those who have psychiatric problems that are beyond the scope of the community-based program, and those who demonstrate little regard for their actions or interest in receiving help.

Timing of Assessments

A professional evaluation of the youth and his appropriateness for placement should be conducted post-adjudication, but prior to court sentencing. Pre-adjudication evaluations are fraught with legal and clinical complexity and are best avoided. Such evaluations may place youths in a position of being asked (oftentimes without legal representation or Fifth Amendment warnings) to reveal information that subsequently may be used in their prosecution. Little meaningful information is derived from assessment of youths who totally deny their offenses. There are no psychological tests that are valid for the purpose of determining issues of innocence or guilt. Furthermore, research suggests that the validity of phallometric assessment may be compromised by client denial.

Components of Clinical Assessment

Clinical assessments should be comprehensive and include careful record review, clinical interviewing, and the administration of both specialized psychometric instruments designed to assess sexual attitudes and interests, and those related to more global personality adjustment and functioning.¹² Adjunctive assessment tools include the plethysmograph and the polygraph.

Assessment of Appropriateness of the Offender's Living Arrangements

It is important that assessments of the juvenile's appropriateness for community-based programming include a thorough review of his living arrangements. This requires evaluation of whether the living environment affords the necessary level of both structure and supervision, and does not compromise the safety of others in the home. Special attention should be given to the needs and concerns of individuals living in the same environment who may have been victimized by the juvenile (e.g., younger siblings). Young children are often not able to advocate for their own best interests in such matters, and must be protected from potential harm, including the potential psychological trauma of having to live in the same home with an individual who has abused them.

For all of the above reasons it is often necessary for the juvenile sex offender to be at

¹² Specialized assessment instruments include: the "Multiphasic Sex Inventory", the "Adolescent Cognitions Scale", and the "Adolescent Sexual Interest Card Sort". Inventories appropriate for children with sexual behavior problems include the "Child Sexual Behavior Inventory". More general assessment instruments of potential use with the juvenile population include: the "MMPI-A"; the "Child Behavior Checklist" (CBCL); the "Family Environment Scale"; and the "Child and Adolescent Functional Assessment Scale" (CAFAS).

least temporarily placed outside of his family home when he has perpetrated against family members. Such juveniles should not be returned home until sufficient clinical progress has been attained and issues of safety and psychological comfort have been satisfactorily resolved. For adjudicated youths, these decisions are typically made by the presiding judge with input from the probation officer and social services worker (if any), the juvenile offender's treatment provider, the provider of services to family victim(s), and the youth's family.

The Organization of Community-Based Programming and Areas of Clinical Focus

The planning and implementation of treatment services should reflect the collaborative involvement of the youth, his family, and all agencies involved in his care. This is best accomplished through the formation of an advisory board that oversees the operation of the program, and serves as an interface between the program and the community. Such boards typically consist of representatives from public institutions serving the youth and his family, including: the local juvenile court, the Department of Social Services, the Prosecutor's Office, the Public Defender's Office, and parents of youthful perpetrators. The advisory board can help to ensure that the treatment program is fully serving the needs of its clients while also meeting community safety standards.

Clinical Treatment and Programming for Juvenile Sex Offenders

Clinical programming for juvenile sex offenders typically includes a combination of individual, group, and family therapies. Additionally, many programs offer supportive psychoeducational groups to the families of these youths. Youths who display more extensive psychiatric or behavioral problems (e.g., substance abuse) may require additional adjunctive therapies (e.g., drug/alcohol treatment; psychiatric care, etc.). All therapies provided to the youth should be carefully coordinated within the treatment agency and with external agencies providing case management and oversight.

• The following have been found by many providers to be important in the effective treatment of juvenile sex offenders:

- The establishment of positive self-esteem and pride in one's cultural heritage.
- The teaching and clarification of values as they relate to a respect for self and others, and a commitment to stop interpersonal violence. Maximally effective programming may include promoting a sense of healthy masculine identity, egalitarian male-female relationships, and a respect for cultural diversity.
- The provision of sex education and an understanding of healthy human sexuality, and the correction of distorted beliefs about appropriate sexual behavior.
- The enhancement of social skills to promote greater self-confidence and social competency.
- The teaching of the impulse control and coping skills needed to successfully manage sexual and aggressive impulses.
- The teaching of assertiveness skills and conflict resolution to manage anger and resolve interpersonal disputes.

- The provision of programming designed to enhance empathy and promote a greater appreciation for the negative impact of sexual abuse on victims and their families.
- The teaching of relapse prevention. This includes teaching offenders to understand the cycle of thoughts, feelings, and events that can trigger sexual acting-out, identify environmental circumstances and thinking patterns that should be avoided because they increase the risk of re-offending, and identify and practice coping and self-control skills necessary for successful behavior management.

CONCLUSION

Juveniles account for a significant percentage of the sexual assaults against children and women in our society. The onset of sexual behavior problems in juveniles appears to be linked to a number of factors, including child maltreatment and exposure to violence and pornography. Emerging research suggests that, as in the case of adult sex offenders, that a meaningful distinction can be made between juveniles who target peers or adults, and those who offend against children. The former group appears generally to be more anti-social and violent, although considerable heterogeneity exists within each population.

Although available data do not suggest that the majority of juvenile sex offenders are destined to become adult sex offenders, legal and mental health intervention is believed, by professionals, to be important in deterring a continuation of such behavior. The most effective intervention is believed to consist of a combination of legal sanctions, monitoring, and specialized clinical programming. Programs reflecting the collaborative efforts of juvenile justice and mental health professions generally report low sexual recidivism rates. Practitioners are advised to be aware of recent legislative reform within juvenile justice, and to adhere to organizational guidelines when working with this population (see standards of the Association for the Treatment of Sexual Abusers; National Task Force on Juvenile Sexual Offending, 1993).

SUGGESTED FURTHER READING

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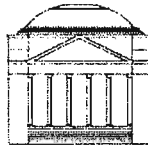
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