

A Special Report on Juvenile Sex Offenders

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National Center for Juvenile Justice
701 Forbes Avenue
Pittsburgh, PA 15219

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Special Report
Juvenile Sex Offenders

by
Douglas W. Thomas
Research Associate

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National Center for Juvenile Justice
701 Forbes Avenue
Pittsburgh, PA 15219
(412) 227-6950

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Introduction

Juvenile sex offenders present a particularly difficult problem for juvenile courts. Sexual offenses are widely considered to be among the most heinous of crimes and elicit very strong emotions from the community, particularly when a person (or persons) in the community has been recently victimized. The dynamics of sexually offending behavior are not widely understood. This behavior remains lurid and murky to most people, including juvenile court professionals. There is a shortage of effective intervention options for juvenile sexual offenders and those that do exist are not widely available to juvenile courts. Where effective intervention options exist, the money to utilize them may not. Finally, cases involving juvenile sex offenders are uncommon enough that many juvenile courts have not developed routines or standard operating procedures for dealing with these offenders.

Surprisingly, until about 15 years ago, sexual offenses committed by juveniles were often dismissed as "adolescent adjustment reactions" or defined as "exploratory experimentation." Less elegantly, sexually abusive behavior committed by males was traditionally rationalized on the basis that "boys-will-be-boys" (Ryan, 1984: 1). Juvenile courts have also contributed to the minimization of this behavior by reducing the charges in sexual offense cases to non-sexual charges. Only recently has the behavior involved in adolescent sexual offending come under critical official scrutiny and special interventions developed (Desktop Guide, 1991: 111 - 112).

The research conducted by the National Center for Juvenile Justice for this report reveals, however, that much has been learned in the past two decades about the phenomenon of sexually offending juveniles and appropriate juvenile court responses to those offenders. For example, there appears to be a general consensus that, at a minimum, intervention for juvenile sexual offenders should: 1) ensure community protection; 2) provide offenders with sex offense specific treatment; and 3) enforce personal accountability for their offenses. The recommended strategy for accomplishing these goals includes a holistic approach requiring a basic understanding of the interdependency between suspected causal factors (i.e.: organicity, family background, history of abuse, or emotional, psychiatric, and intellectual dysfunc-

tion). It also requires an understanding of the progressive relationship which links victims of sexual abuse, sexually reactive children, pre-adolescent and adolescent sex offenders, and adult sex offenders (Utah Governor's Council, 1990: 2).

This approach works best within a continuum of community services that includes prevention, identification and reporting, investigation, adjudication, assessment, supervision, clinical intervention, and research. Such a continuum of services requires cooperation between and among the agencies that share responsibility for addressing this issue (i.e.: police, social welfare, child protective services, community mental health agencies, the juvenile court, private service providers, corrections, and aftercare).

Although the number of reported sexual offenses committed by juveniles is relatively low, the impact of these offenses on the victim, the victim's family, and the community can be devastating. The statistically underwhelming incidence of reported sexual offenses belies the true scope of this problem for a variety of reasons: sexual offenses are grossly underreported (Oregon Working Committee, 1986: 14); research indicates that sexually offending behavior begins in adolescence and remains with the offender well into adulthood (Groth, et al, 1982); sexual offenders are rarely one-time offenders and the incidence of sexually offending behavior increases with age (Abel, et al, 1983); and sexually offending behavior appears to be a self-perpetuating phenomenon (Longo, 1982: 235).

The importance of early intervention in the careers of juvenile sexual offenders cannot be overstated. Not only will early intervention go a long way toward identifying juvenile sex offenders and protecting the community from further victimization, but intervening in the sexually offensive behavior of adolescents has a number of benefits for treatment as well: 1) deviant patterns are less deeply ingrained in adolescents and easier to address successfully; 2) youths are still experimenting with a variety of patterns of sexual satisfaction which affects alternatives to consistent deviant patterns; 3) distorted thinking patterns are less deeply entrenched and can be redirected; 4) youth are good candidates for learning new and acceptable social skills; 5) fiscal economy is en-

hanced due to reduced victimization and relatively lower costs of treatment vs incarceration (Knopp, 1985: 12).

The purpose of this Special Report on Juvenile Sexual Offenders is to present a blueprint for early, determined, and consistent intervention in the lives of young sex offenders. This report will provide an operational definition of juvenile sexual offenders, a discussion of the scope of the problem of juvenile sexual offending, an analysis of disposition options available to the juvenile court, and a discussion of treatment alternatives available for juvenile sexual offenders. It is not intended to be the definitive work in this area, but hopefully the Special Report will provide juvenile justice professionals with a reasonable point of departure for developing policies, procedures and practices for dealing effectively with this special population.

Juvenile Sexual Offender Defined

Effective juvenile court responses to sexual offenders requires that all key juvenile court personnel should be thoroughly familiar with issues of human sexuality (particularly deviant human sexuality), the definitive characteristics of the juvenile sexual offender, and the law as it relates to sexual offenses by juveniles. To prevent juvenile sexual offenders from avoiding detection and/or formal intervention within the juvenile court process, it is extremely important that juvenile courts establish an explicit operational definition of the juvenile sexual offender and insure that all staff are familiar with the basic characteristics of juvenile sexual offenders.

A juvenile sexual offender is a person below the age of legal majority who commits one or more legally proscribed sexual acts. Sexual acts may include anything from non-contact offensives (voyeurism, exhibitionism) to violent physical assaults (rape, sodomy). Whether or not a sexual act is considered to be criminally offensive is usually determined by one or more of the following characteristics:

- A clear power differential between the victim and the offender.
- Exploitation.
- Emotional or physical coercion.
- Abusive manipulation, control, or abuse of power.
- Threats of violence.

Most formal definitions of the juvenile sexual offender include guidelines that address both the sexual act itself and elements of power differentials between the perpetrator and the victim. They include the following criteria: 1) the type of sexual activity; 2) the age relationship between the persons involved in the act; 3) the social relationship between the persons involved; and 4) the elements of coercion involved in the incident. For example, Gail Ryan, of the C. Henry Kempe National Center for the Prevention of Child Abuse and Neglect, emphasizes power differentials when she defines the juvenile sexual offender as "a youth from puberty to the legal age of majority, who commits a sexual act with a person of any age, against the victim's will, without consent, or in an aggressive, exploitative, or threatening manner (Ryan, et al, 1987: 3).

Réliance upon individual value judgements about what is appropriate sexual behavior or not may lead courts into an area of legal and conceptual ambiguity that can hinder attempts to make appropriate dispositions for juvenile sexual offenders. In fact, a chronic lack of knowledge among juvenile court professionals regarding human sexuality, particularly deviant human sexuality, has been one of the traditional obstacles to making appropriate disposition decisions for juvenile sexual offenders. Certain sexual behaviors are unambiguously harmful to others and these behaviors have, more often than not, been identified and declared illegal. Intervention in cases involving a sexual offense committed by juveniles should be based upon discretely articulated legal constructs addressing clearly harmful sexual behaviors (National Task Force, 1988).

Statutory definitions of sexually offensive behavior usually encompass a wide array of behaviors of ever increasing seriousness, from non-contact sexual offenses like voyeurism to serious assaultive offenses including violent rape. The seriousness of a sexual assault is usually determined by a number of discretely measurable factors including:

- The extent of the victim's trauma and/or injuries.
- The age differential between victim and the offender.
- Power differential between the offender and the victim

- Intellectual imbalance between the offender and the victim.
- Inequitable status relationships.

A technically explicit definition of juvenile sexual offenders employing the characteristics described above is provided by the Utah Task Force on Juveniles Offending Sexually which recommends the following guidelines for defining the juvenile sexual offender:

- A) Any juvenile below the age of original juvenile court delinquency jurisdiction (18 as defined in the Utah Criminal Code Annotated).
- B) The act might be defined as a sexual offense if it meets any one of the following criteria:
 1. Power Differential.
 - a. Age Difference.
 - b. Larger physical size.
 - c. Greater mental capacity.
 - d. Greater physical capacity.
 2. Role Differential.
 - a. The assumption of authority of one person over another (i.e.: babysitting relationship).
 3. Predatory Patterns.
 - a. Any behavior that suggests setting-up the victim, such as stalking, pre-planning, and/or special treatment of the victim.
 4. Elements of Coercion.
 - a. Any behavior used to secure the victim's trust, to intimidate and/or manipulate the victim to perform an act to which they would not otherwise consent (i.e.: games, tricks, bribes, threats, or use of weapons and/or force).
- C) The sexual act may include any of the following:
 1. Direct physical contact, invasive offenses.
 - a. Fondling.
 - b. Frottage.
 - c. Digital penetration of vagina or anus.
 - d. Oral copulation.
 - e. Object insertion into vagina or anus.
 - f. Penile penetration of vagina or anus.
 2. "Hands-off" Offenses.
 - a. Voyeurism.
 - b. Exhibitionism.
 - c. Obscene Phone calls (Utah Task Force, 1989: 6).

Juvenile Sexual Offender Typologies

There is no single distinguishing characteristic of the juvenile sexual offender, nor is there a unique set of distinguishing characteristics. Youthful and adolescent sexual offenders may come from any age group and all strata of society - wealthy, poor, middle class. Although most reported sexual offenses are committed by males, females also commit these offenses. No race owns a monopoly on sexual offenses. Sexual offenses are committed by person's known to the victim as well as strangers. The only characteristic that clearly distinguishes adolescent sexual offenders from other young people is that he or she has committed a sexual offense.

Although it is not possible to describe the prototype adolescent sexual offender, typologies have been developed to increase our understanding of sexual offenders and, as a result, our ability to respond to them. For example, Michael O'Brien and Walter Bera of the Program for Healthy Adolescent Sexual Expression (PHASE) have developed a typology of adolescent sexual offenders based on characteristics of adolescent development. The PHASE typology identifies seven main categories of offenders by assessing several individual characteristics including: age of the offender, nature of the offense, previous sexually offensive behavior, social skills and socialization, family background, emotional and psychological development, drug and alcohol usage, cognitive abilities, intelligence, and academic performance among others. This typology, widely considered to be a classic in the field of juvenile sex offender assessment, has been adopted by many treatment programs and state guidelines for classifying juvenile offenders (Utah Task Force Report, 1989: 4).

The seven PHASE categories are:

- 1) Naive Experimenters: Tend to be younger adolescents (12 -15); no previous history of acting-out problems; adequate social skills/socialization; lack of sexual knowledge and experience; sexual events are isolated, opportunistic, exploratory, situational, non-violent acts with younger children.
- 2) Under-Socialized Child Exploiters: More extensive patterns of sexual behavior with younger children affected through manipulation, enticement, entrapment; chronic social isolation and poor social skills; no history of other acting out behavior; Inadequacy, insecurity, low self-

worth predominate; family disengaged, father distant.

- 3) **Sexual Aggressives:** Use of force or violence in commission of sexual assaults against peers, adults, or older children; socially and sexually active with peer group; history of antisocial, acting-out behaviors from early childhood; likely to be using alcohol and/or drugs regularly; difficulty handling aggressive impulses; oversensitive to criticism, tense and anxious, emotionally labile; uses primarily denial and projection as defenses; family characterized by chaos, abuse, violence.
- 4) **Sexual Compulsives:** Engages in repetitive sexually arousing behavior that becomes compulsive, addictive in nature; usually hands-off behavior such as voyeurism, obscene phone calling, exhibitionism, fetish burglary; quiet, socially withdrawn, may be studious, tending toward overachievement and perfectionism; constant state of tension and anxiety due to hypersensitivity to failure; inability to express anger appropriately; emotional constraint and anxiety results in tension-reducing acting-out behaviors that involve sexual arousal; behavior becomes patterned, cyclical, and repetitive because it is re-enforcing; family system rigidly enmeshed with closed external boundaries; parents may adhere to rigid and fundamentalist religiosity.
- 5) **Disturbed Impulsives:** Sexual offense is impulsive and signifies acute disturbance; offense may be single, unpredictable, uncharacteristic act or pattern of bizarre and/or ritualistic acts; offenses reflect malfunction of normal inhibitory mechanisms due to thought disorder caused by psychosis either endogenous or drug induced.
- 6) **Group-Influenced Offenders:** Sexual offense is an attempt to impress peers, gain approval or acceptance, or prove oneself in peer's presence, e.g., gang rape, "dare" exposing, bathroom abductions; usually no history, personality and family characteristics normal.
- 7) **Pseudo-Socialized:** Active peers, but manipulative relationships, superficial; narcissistic quality - they play on being special, unique, immune to other people's pain; sociopathic streak; normal on testing; likes to break rules and not get caught, stealing, etc.; seemingly lots of friends, gifted, successful; magnetic, facile in group, plays at social wellness; lack of intimacy - family has high expectations, little closeness; do well in school, high IQ, hang around with adults; love being viewed as precocious; air of superiority; love to do, dream of very adventurous things;

lacking intimacy skills, also their fathers lack intimacy skills while appearing very successful (O'Brien and Bera, 1980).

Applying uniform, consistent, and clear language to cases involving juvenile sexual offenses will assist referral sources, policymakers, court staff and juvenile court judges in understanding sexually offending behavior by juveniles. A standard language will also facilitate communication between all of the major actors involved in making dispositional and treatment decisions for this specialized population.

Scope of the Problem

Sexually offensive behavior committed by juveniles represents a serious social dysfunction for the offender, a tragedy for the victim, a threat to the community, and an extremely complicated challenge for the juvenile court. Amazingly, the true scope of the problem has only recently begun to be recognized and measured. Historically, juveniles involved in sexually offending behaviors were not held accountable for the criminal nature of their acts or the impact of those acts on their victims (National Task Force, 1988: 5). Adolescent sexual behaviors which were clearly exploitive and criminal were traditionally dismissed under the rubric of "adolescent adjustment reactions" or "exploratory experimentation" (Utah Task Force, 1989: 3). Even when cases involving juvenile sexual offenses were brought to the attention of the court, charges were frequently reduced to non-sexual charges (Desktop Guide, 1991: 111). As a result of the traditional denial and minimization of sex offenses committed by juveniles, our knowledge of the extent of sexual offenses committed by juveniles and the impact of those offenses on the juvenile court remains murky.

To gain a better understanding of the impact of juvenile sexual offenders requires a careful analysis of the available statistics on these offenses and consideration of some of the human costs of sexual victimization. Unfortunately, reliable data on these issues is scarce.

The Nature and Extent of Sexual Offenses Committed by Juveniles

It is not possible to determine accurately the incidence of sexually assaultive youth in our society. Exact counts are unavailable and estimates are methodologically suspect. Still, it is clear to most observers of sexual

offending behavior by juveniles that such acts are pervasive, under-reported and a major cause of concern (Knopp, 1985: 6). Most of the information we have on the incidence and scope of juvenile sexual offending comes from three primary sources: 1) arrest data; 2) juvenile court data; and 3) research conducted on adult sex offenders who are either incarcerated or in treatment.

Arrests for rape and other sexual offenses represent just a small proportion of the total arrests in the U.S. Of the estimated 14,195,000 arrests in 1990, it was estimated that about 1% were for sex offenses (Crime in the United States 1990: Table 24). However, a close look at arrests for sexual offenses reveals that persons under the age of 18 account for a large proportion of those offenses. For example, using data from the Crime in the United States 1990 report, the National Center for Juvenile Justice estimates that youths under the age of eighteen account for 15% of all arrests for forcible rape and 16% of the arrests for other sex offenses (Snyder, 1992: Table 1).

Just as sex offenses represent only a small proportion of reported arrests, sex offense cases represent a small proportion of the cases processed by the juvenile courts. For example, sex related offenses account for less than 2% of the 1,189,200 delinquency cases processed by juvenile courts in 1989. For comparison consider the relative proportion of the cases processed through the juvenile courts for: criminal homicide (0.2%); robbery (2%); aggravated assault (4%); burglary (10%); larceny-theft (26%); simple assault (9%); and drug and liquor law violations (8%) (Snyder, et al., 1992: Table 1).

Although recent years have yielded a decrease in the number of forcible rape cases processed by the juvenile courts, there appears to be some evidence that the problem of juvenile sexual offending is increasingly coming to the attention of the juvenile court. The number of forcible rape cases being processed by the juvenile courts decreased by 3% between 1988 and 1989. Between 1985 and 1989 the decrease was 9%. However, the number of cases processed by the juvenile courts increased for "other violent sexual offenses" (8%) and for "other sexual offenses" (13%) between 1988 and 1989 (Snyder, et al, 1992: Table 1). The Uniform Crime Reporting Program reports that the arrests of persons under the age of 18 for forcible rape has increased from a rate of 4.9 per 100,000 in 1965 to 9.1 per 100,000 in

1989. For most of the 1980's, however, this rate has hovered between 7.7 (1980) and 9.5 (1986) (Uniform Crime Reporting Program 1991; 272).

The NCJJ Archive project reports that the proportion of sex offense cases processed by the juvenile court has increased from 1.6% in 1984 (Snyder, et al, 1987, Table 1) to 1.9% in 1989 (Snyder, et al, 1992: Table 1). The apparent increase in numbers of juvenile sex offense cases referred to the juvenile courts may be related to: 1) an increased awareness in society about the importance of reporting sex offense cases; 2) increased reporting requirements for state and local officials; and 3) an actual increase in the number of youths committing sexual offenses. Whether the increase in the number of sexual offenses being processed by the juvenile courts represents an improvement in reporting procedures or an epidemic of sexual offenses, one thing is clear - juvenile courts are being asked increasingly to deal with this problem. Unfortunately, because cases involving juvenile sexual offenders have been relatively uncommon, courts have not developed routines or procedures for dealing with this very specialized population. As a result, even a marginal increase in the volume of sexual offenders entering the juvenile court will exacerbate the problem.

The official statistics, however, do not tell the whole story of the extent of the problem posed by juvenile sexual offenders in the U.S. A major reason is simply because many cases of sexual victimization are not recorded in the official statistics. There is a great deal of evidence to indicate that the cases of sexual victimization that appear in official records and consequently in the official statistics represent only a small proportion of the actual number of sexual assaults committed. (Oregon Working Committee, 1986; National Task Force, 1988; Utah Task Force Report, 1989) The official statistics underreport the problem for a variety of reasons, including: 1) the exclusion of all sex offenses other than rape and attempted rape from some data collection efforts; 2) victims under the age of 12 are not included in victimization surveys; 3) data collection procedures are inconsistent across sites; 3) social norms encourage underreporting of sexual offenses; 4) complexity of the crime; 5) age of the offender and familiarity with the victim may discourage reporting; 6) the victim is often reluctant to report; 7) family minimization of the offense;

8) official agency minimization of the offense; 9) the offender is often reluctant to report; 10) common juvenile justice practices - e.g.: plea bargaining and other juvenile court negotiations and decisions.

In addition, there is a large body of research which demonstrates that sexually offending behavior begins early, is as tenacious as it is pernicious, and, if left unchecked, can be prolific. Data from studies of incarcerated and non-incarcerated adult sexual offenders indicate that a career of sexually offending behavior may begin at an early age and involve multiple victims over many years. One study of 137 incarcerated rapists and child molesters, for example, revealed that almost half of these men had committed their first sexual offense between the ages of eight and 18. Child molesters reported committing their first offense as early as eight years of age and their first rape as early as nine years old (Groth, et al, 1981).

Adolescent sexual offenders are also not likely to grow out of their offending patterns without professional intervention (Bengis, 1986:5). For example, a study of 306 adult sexual offenders revealed that 42% had established a deviant arousal pattern by the age of 15 or before and 57% by the age of 19 or before (Abel, et al. 1983: 4). In another study, this time involving 411 nonincarcerated sex offenders, half of the adult offenders in the study experienced deviant arousal as adolescents (Abel, et al., 1983).

Career sexual offenders demonstrate a prolific capacity for victimization. Data collected on 232 child molesters whose victims were less than 14 years old revealed that they had attempted a total of 55,250 molestations and completed 38,727. Their total number of victims was 17,585. They averaged 238 attempted and 167 completed child molestations each. The average number of victims was 75.8 each (Abel, et al., 1984). However, recent studies on adolescent sexual offenders reveals an average of less than 7 victims (National Task Force Report, 1988: 5).

The implications are clear. First, each reported case of a sexual offense does not come close to indicating the actual level of victimization that has occurred. Second, early intervention in the career of sexual offenders can dramatically reduce the number of potential victims and, as a result reduce the costs - personal, emotional, and fiscal - of sexual offenses.

The Human Costs of Sexual Victimization

The true impact of sexual victimization, however, cannot be adequately demonstrated by statistical analyses. As Lucy Berliner reported during a conference on "Successful Interventions with Sex Offenders" conducted by the Washington State Institute for Public Policy, there are very serious human costs associated with sexual victimization as well. She highlighted two general sources of harm to a victim of sexual assault that are related to the criminal experience. The first source of harm consists of the physical harm as well as the intense fear and anxiety evoked during the actual victimization. These feelings then become associated with the memory of the experience and with the events that remind the victim of the experience. These feelings are very likely to result in an anxiety disorder known as Post-Traumatic Stress Disorder (PTSD). PTSD is connected to a traumatic event, like rape, and recurs in the form of intrusive thoughts, flashbacks, nightmares, and other kinds of responses to a fear producing experience.

A second source of harm involves alterations in the victim's views about themselves, other people, and the world at large. The personal world view of victims of sexual assaults can often become dark and negative. They come to believe that they were inalterably changed by the incident, that other people are untrustworthy, and that the world is a dangerous place.

Research findings on the long-term affects on adults who were abused as children are dramatic. They show higher levels of psychological distress, particularly symptoms of anxiety, than adults who were not victimized. They were twice as likely to be diagnosed with depression. Adults who were victimized as children are also at greater risk of being re-victimized in other situations and having difficulties with interpersonal relationships (Berliner, 1991: 8).

The Juvenile Court Response to Juvenile Sexual Offenders

The decisions made during the juvenile court disposition hearing are critical to the future of both the juvenile and the community. The determination of the length of the disposition, the degree of restraint that should be imposed, and the type of program to which the juvenile should be assigned is particularly difficult in cases involving juvenile sexual offenders. (Desktop

Guide, 1991: 41). Determination of the appropriate dispositions for juvenile sexual offenders requires that the court carefully assess: 1) the specific nature of the sexual offense(s) committed; 2) the treatment needs of the offender, including the offender's amenability to treatment; 3) the youth's continued threat to the victim(s) and to the community; and 4) the available sex offender specific treatment resources.

A special analysis of 513,244 juvenile court cases representing 15 states* provides some insight. The analysis confirmed our knowledge of the relatively low proportion of sex offense cases being processed by the juvenile courts, revealing that only 1.6% (8,057) of these cases were for sex offenses.

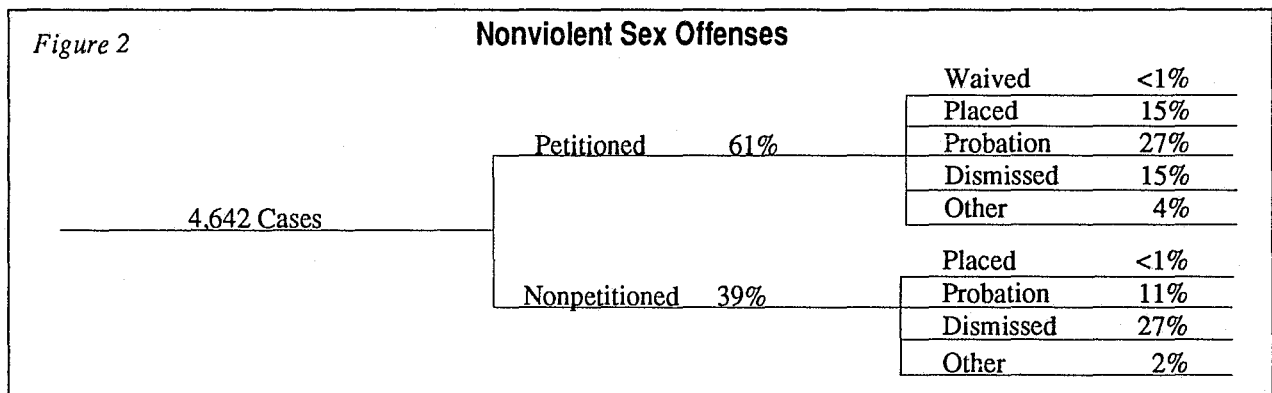
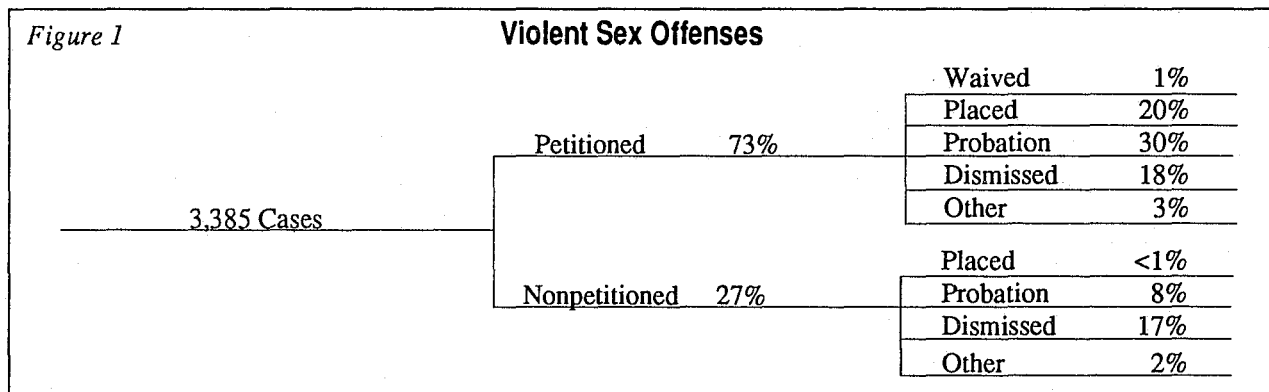
Of the 8,057 sex offense cases identified in the analysis, non-violent sex offenses (indecent exposure, voyeurism, and prostitution) accounted for 58% of the offenses, with violent sex offenses (rape, sodomy, aggravated sexual battery) accounting for 42%. Demographically, males accounted for 93% of all sexual offense cases in the sample. The proportion of male involvement increased to 97% in cases involving violent sex offense cases. Females were more likely to be involved in non-violent (10%) than violent (3%) sexual offenses, reflecting the inclusion of prostitution in the

non-violent sex offense category. Almost 71% of the cases in the sample involved youths from 14 to 17 years old.

Figures 1 and 2 illustrate how the courts responded to violent and nonviolent sex offense cases included in the special analysis. In general, most of these cases resulted in probation or dismissal. Out of home placement occurred in less than one fifth of the cases. Very few of the sex offense cases included in this analysis were waived to adult court.

Figure 1 represents the 3,385 violent sex offenses included in the analysis. Almost three quarters of those cases resulted in a formal petition. Thirty-eight percent of all violent sex offense cases (both petitioned and non-petitioned) resulted in probation. The next most common response for violent sex offenses was dismissal, with 35% of all these cases being dismissed. Barely 20% of these cases resulted in an out of home placement. Slightly over 1% of cases involving violent sexual offenses were waived to adult court.

Figure 2 represents the 4,642 nonviolent sex offenses included in the analysis. Less than two thirds of those cases resulted in a formal petition. Slightly over 41% of all nonviolent sex offense cases (both petitioned and non-



petitioned) resulted in dismissal, which was the most common juvenile court response for those offenses. Probation was the disposition in 38% of all nonviolent sex offenses. Slightly more than 15% of these cases resulted in an out of home placement. Less than 1% of cases involving nonviolent sexual offenses were waived to adult court.

Obstacles to Appropriate Dispositions

There are any number of obstacles to making appropriate treatment and placement decisions for juvenile sexual offenders including a lack of adequate resources designed specifically for juvenile sexual offenders and inconsistencies in juvenile court practices. In a recent survey of juvenile probation agencies only 25% of the agencies responding to the survey indicated that they had adequate treatment and placement resources for juvenile sexual offenders (NCJJ Survey, 1991). Although recent years have seen a rapid proliferation of treatment options for juvenile sexual offenders (Knopp, 1990), the equally rapid growth in the identification of juvenile sexual offenders ensures that the demand for sex offender-specific placement options will continue to exceed the supply. This will be especially true in those jurisdictions already lacking a full continuum of resources for juvenile sexual offenders.

The supply/demand equation is not the only obstacle to making appropriate decisions regarding juvenile sexual offenders. Inconsistencies in juvenile court practices also hamper efforts to provide timely, appropriate, and effective treatment for these offenders, including inconsistencies in:

- Ordering treatment for juvenile sexual offenders.
- Mandating the participation of the juvenile sexual offender and his/her family in treatment.
- Requiring the offender's parents to accept financial responsibility for their child's treatment.
- Referring juvenile sexual offenders to treatment programs that specifically confront sexually inappropriate behavior.
- Monitoring the progress of juvenile sex offenders in their treatment programs.
- Applying immediate consequences for lack of participation or inadequate progress in treatment (Utah Task Force, 1989: 25).

Predispositional Assessment of Juvenile Sexual Offenders

The lack of adequate placement options for juvenile sexual offenders and the inconsistencies in juvenile court procedures mandates that juvenile courts take special care to match the offender with the most appropriate treatment option available. This level of accuracy in placement decisions requires careful assessment of the treatment needs of the individual offender. Unfortunately, there are no validated instruments available to reliably classify juvenile sexual offenders. As a result, juvenile sex offenders must be assessed individually using a combination of known clinical indicators and suspected risk factors. Because the issues are so complex and no "user-friendly" assessment instrument exists, it is recommended that juvenile courts retain the services of an officially sanctioned group of qualified therapists who can conduct specialized evaluations of sexual offenders for the court (National Task Force, 1988: 20).

A thorough assessment of the needs of the offender and the risk that he or she poses to the victim or the community is the best way of assuring that the resources available to the court are used most efficiently. Courts should design, develop, and adopt a standardized system for collecting and categorizing juvenile sexual offender assessment information. Such a system will help to ensure the consistency and reliability of the assessment information for juvenile sexual offenders. At a minimum, the following information should be considered.

- **Offender's Background:** Family background, academic and social performance in school.
- **Alcohol and Drug Use:** Although the link between sexually offending behavior and alcohol and substance abuse is not clearly understood, there appears to be some relationship. It is important to determine if the youth has an alcohol and/or substance abuse problem and plan treatment with that information in mind.
- **Offense History:** Determine if the offense is the first or another in a long history of sexual offenses, and if the sexually offending behavior is escalating.
- **Mental Status Inventory:** The offender's mental status and/or tendency toward exhibiting delinquent behavior, and whether there has been any previous involvement with treatment.
- **Intellectual Functioning Inventory:** The offender's intellectual capabilities and likely ability to complete a specific treatment modality.

- **Sexual Profile:** Information about the juvenile's sexual history. This should include specific data about the alleged crime under investigation or for which treatment is being sought as well as about any other sexual offenses.
- **Sexual Arousal Assessment:** To determine the degree of deviant sexual fixation or compulsion.
- **Victim's Issues:** Information concerning the willingness of the victim and/or the victim's family to contribute or cooperate with a treatment program.
- **Strengths and Weaknesses:** The offender's unique strengths and weaknesses pertaining to specific rehabilitation and treatment modality issues.
- **Risk of Reoffending:** Identify and consider risk factors that indicate whether or not the offender is a risk to himself, the victim, or the community. This determination should inform the decision to treat in the community or in a more secure setting.
- **Summary and Treatment Recommendations:** A summary prognosis for the juvenile sexual offender in responding to treatment. The summary should include a brief assessment of risk - to the offender and the community- and a recommended treatment modality (Oregon Report on Juvenile Sexual Offenders, 1986: 29, 52-53).
- Acknowledge the offending behavior and demand accountability from the young person;
- Provide specialized sex-offender assessment, evaluation, and treatment in order to interrupt the behavior therapeutically as early as possible; and
- Identify and select the proper placement from a range of treatment settings, including community-based, non-residential through secure residential, followed by post treatment follow-up and aftercare (Knopp, 1985: 6-7).

Juvenile Sexual Offender and Diversion

Diversion is not generally recommended as an option for juvenile sexual offenders. The National Task Force, for example, advocates formal adjudication as the preferable course of action in cases involving juvenile sexual offenders. Formal adjudication provides support for the victim's rights, a means to assure community safety, and a mechanism to prevent further victimization. Furthermore, diversion may be viewed by the offender as a reduction in the consequences for his actions and contribute to the offender's minimization of the offense. Formal adjudication for juvenile sexual offenses: 1) prevents further victimization; 2) protects the community; 3) assures complete investigation of the complaint; 4) demonstrates that the offense is serious and will not be tolerated; 5) holds the offender accountable for behavior; 6) determines consequences of the behavior; 7) supports victim's rights and reduces minimization and denial by the offender; 8) addresses need for treatment; 9) facilitates entrance into sexual offender specific treatment program / enhances offenders motivation to change; 10) assures continued treatment; 11) provides for supervision and aftercare; 12) documents record of offending (National Task Force, 1988: 16).

However, diversion may be appropriate under limited circumstances. It may be considered, for example, when the offender has admitted guilt, has a record of successful participation and / or completion of sex offender specific treatment, and does not have a record of additional delinquent or criminal behavior. Diversion, if used, should be as closely supervised as probation or parole with a clear understanding that the court will pursue formal adjudication if the offender does not cooperate with the diversion contract or agreement (National Task Force, 1988: 16). In addition, diversion should not be considered unless:

Other issues that may be considered during the pre-disposition assessment for juvenile sexual offenders include: the dynamics / process of victim selection; use of force, violence, and weapons; ritualistic processes; deviant sexual interests; deviant non-sexual interests; victim empathy issues; denial or minimization; impulse control; and organicity and neuro-psychological factors. (For a comprehensive listing of assessment issues for juvenile sexual offenders, see the "Preliminary Report of the National Task Force on Juvenile Sexual Offending, 1988.")

Appropriate Responses to Juvenile Sexual Offenses

Fay Honey Knopp argues, sensibly enough, that the appropriate response to a juvenile sexual offense usually lies somewhere between two clearly inappropriate options: 1) No Response - do nothing, ignore the behavior, fail to demand accountability; and 2) Incarceration Only - lock-up adolescent sexual offenders with no possibility for treatment. She specifies that the optimal judicial response to juvenile sexual offenders will:

- The safety of the victim is assured.
- The offender admits responsibility for the sex offense and volunteers for treatment.
- The offender is at low risk for re-offending.
- The family is highly motivated to participate fully in specialized treatment.
- Treatment resources are immediately available, and the family verifies that they have contracted for treatment.
- When the offender is very young, between the ages of 7 and 10, diversion should be the preferred option.
- The system of treatment services in the community where the offender resides is advanced, maximizing offender accountability and monitoring (Stickrod, 1988).

Intervention Options for Juvenile Sexual Offenders

Generally speaking, a broad range of interventions should be available to the juvenile court for disposing cases involving juvenile sexual offenses. This range should be sufficient to meet the needs of individual offenders, the needs of offenders at different stages in their treatment, and the needs of the community. Services for juvenile sexual offenders should be sex offense specific and available along the full continuum of court supervision - from diversion and informal supervision to incarceration. The range of interventions available to the juvenile court should be sequenced, adaptable, interactive, flexible, share a common treatment philosophy, and include the following alternatives:

- **Probation Supervision:** Juvenile sex offenders released into the community on probation must have strict conditions of probation associated with sex offense specific treatment. Some form of intensive probation supervision is recommended. The court may wish to consider other offense specific restrictions to the conditions of probation, including restrictions against contact with victim, prohibiting baby-sitting or camp counseling, if incest is involved, requirements to live some place other than home.
- **Fines, Restitution, Community Service:** Court imposed fines, restitution orders, and community service requirements can confront the offender with the consequences of his actions, help to illustrate the seriousness of the offense and assist in the therapeutic process by linking the court imposed sanctions with reparative actions.
- **Continue Treatment in Progress:** If the offender and his family have already initiated voluntary treatment, it is recommended that the court cooperate with the family and the treatment provider.
- **Community Based Treatment:** This intervention emphasizes education and is generally appropriate for younger offenders without a history of sexually offensive behavior or other delinquent activities. This offender possesses adequate social skills and can function effectively in most aspects of his life. Events of sexually acting out are usually isolated, opportunistic, exploratory, situational and non-violent. Juvenile poses little risk to himself or the community. A "naive experimenter" in the PHASE typology.
- **Community Outpatient Program:** The offender will live in his own home or a foster home. These programs are designed for more troubled adolescent sexual offenders. The offender appropriate for this level of intervention usually possesses poor social skills, but has no history of other sexually offensive or delinquent behavior. For this level of intervention to be appropriate, the offender must acknowledge responsibility for sexual acts. Formal adjudication is highly recommended.
- **Day Treatment Programs:** This setting provides maximum community protection in the least restrictive setting, with parents and care providers closely supervising the offender. This level of intervention is appropriate for offenders who require structured treatment, yet are capable of functioning in the community. The candidates for this level of supervision may represent a wide range of sexual offenses from child molestation to rape. The offender must acknowledge responsibility for sexual acts. This option requires a viable family for support and supervision. Formal adjudication is necessary.
- **Group Homes and Child Care Centers:** Community based residential care may be appropriate for offenders with poor social skills, low self-image, history of delinquency. Sexual offenses characterized by younger victims, manipulation, enticement, entrapment, moderate coercion. Family is unable to adequately control the youth, may be involved in "enabling" behavior, family dysfunctions. Formal adjudication is desirable.
- **Training Schools:** Secure institutional settings, not necessarily treatment-based environment. Appropriate for youths with history of extensive delinquent behavior and failure in community based programs. Sexually offending behavior

may include incest. Offender comes from a chaotic family, possibly with history of violence and running away. Formal adjudication required.

- **Secure Units:** Treatment oriented, secure residential units. Positive peer culture, trained staff, carefully selected and matched with offender. Offender deemed to be unsafe in community. Offender used force or violence in commission of offense. Victims include adults, peers, children. Established history of anti-social acting out behavior. Offender does not accept responsibility for behavior, uses primarily denial and projection as defenses. Offender feels inadequate, has poor impulse control, rigid value system, psychiatrically disordered. Formal Adjudication required (Oregon Report, 1986: 29a-29b).

Treatment Issues

The specific purpose of treatment for adolescent sexual offenders is to help the juvenile gain control over his deviant sexual behavior and to teach, encourage, and support pro-social interactions. Treatment for juvenile sexual offenders is best conceptualized as an integrated continuum of specialized services extending from the initial assessment to post-release activities. Appropriate treatment for juvenile sexual offenders must be specialized because:

- Traditional diagnostic assessments do not provide sufficient data to allow for appropriate placement and intervention decisions;
- Traditional treatment fails to impact successfully on the non-compliant client who does not voluntarily seek treatment, denies his problems, and is engaged in potentially obsessive, ritualized and addictive behaviors; and
- Sex offenders may pose a serious risk to the community (Bengis, 1986: 7).

Provision of treatment alone, even specialized treatment, may not be sufficient without the legal support of the juvenile justice system. Similarly, prosecution and incarceration by themselves are insufficient without a meaningful treatment component. The close supervision and monitoring of juvenile sexual offenders being treated in the community is essential for therapeutic purposes as well as for reasons of community safety.

A sound theoretical foundation is a pre-requisite for effective treatment of any sort and, as one might expect, there is no shortage of theories related to the causation

and treatment of sexually offensive behavior. The National Task Force provides a sampling of some of the theoretical constructs addressing deviant sexual behavior (chief proponents in parentheses):

- Deviant sexual arousal patterns develop in response to victimization or by results of learned behavior and socialization over time (Groth, 1979; Longo, 1982; and Abel and Blanchard).
- Feelings of powerlessness and lack of control may trigger a sexual assault cycle with identifiable precursors, progressions, and antecedents; the cycle can be identified and intervention strategies developed to stop it (Lane and Zamora, 1985; Ryan, Lane, Davis, and Isaac).
- Sex offenses may be the outcome of an antisocial way of looking at life and irrational thinking patterns (Yochelson and Samenow).
- Developmental problems may contribute to sexually aggressive behavior leading to a fixated or regressive pattern (Piaget and Kholberg; Groth, et al).
- Psychological and physiological reinforcement in sexually aggressive behavior may lead to addictive behavior (Carnes, Freeman-Longo).
- Sex offenses may be symptomatic of intrapsychic conflict (Groth).
- Masturbation to deviant fantasies may lead to sexually aggressive behavior (Abel and Blanchard; Marshal).
- The family and environment are essential influences in the development of sexuality and, therefore, family trauma, physical and sexual abuse, neglect, scapegoating, undefined family relations, and exposure to sexually traumatic material in the environment may contribute to the development of sexually offending behavior (Steele, Longo).
- There are different etiologies and factors associated with offending by different individuals (Groth, et al; Finkelhor).
- Sexual deviancy may involve physiological variables (Berlin).
- Sexual deviancy is the result of normative developmental processes which strive for interdependency and intimacy but are expressed in socially unacceptable behaviors (Bremer and Ellis).
- Sexual deviancy may develop over time, and may progress to include additional escalating sexual deviancies. For example, hands-off

behavior may precede hands-on and nonviolent behavior may precede violent behavior (Longo; Groth; Abel).

- Sex offenders experience a cognitive inability to distinguish sexual from non-sexual behaviors, stimuli and responses (Murphy, Coleman, and Haynes) (National Task Force, 1988: 31).

Because sexual aggression is such a complicated, multi-dimensional phenomenon, treatment methods must be sophisticated, individually oriented, and multi-modal. In fact, most existing treatment interventions for sex offenders draw on a combination of theories. Treatment plans may address any one, or any combination, of the following treatment issues:

- Denial, minimization, projecting blame.
- Accountability for all offending or exploitive behaviors.
- Thinking errors / irrational thinking.
- History of offending behavior.
- Self-responsibility in offense and nonoffense areas.
- Irresponsible decision-making / high risk behaviors.
- Empathy development / victim personalization.
- Long-term management of sexually deviant impulses.
- History of offender's own victimization.
- Life history / autobiography.
- Helplessness and lack of control.
- Delusions of persecution.
- Impulsivity and poor judgement.
- Anger management and frustration tolerance.
- Values clarification, including victim empathy.
- Substance abuse / addictive behaviors.
- Arousal patterns / deviant fantasizing.
- Positive sexual identity development.
- Communication and social skills training.
- Family dysfunction and sibling issues. and
- Educational issues (National Task Force, 1988: p. 21).

Treatment Methods

Many methods and techniques are employed by treatment providers to interrupt sexually offensive

behaviors in individuals. Rarely are these methods or techniques used in isolation. Rather, they are selectively combined to address the complex sexually dysfunctional behavior of individual offenders. The methods employed to treat juvenile sexual offenders may be applied in residential or non-residential programs, in varying degrees of intensity, and for different lengths of time depending on the particular characteristics or treatment needs of the offender.

Whatever the treatment method, the treatment goals remain relatively constant. The Prison Research / Education / Action Project (PREAP) identifies six standard comprehensive treatment goals:

- **Provide Individualized Assessment and Treatment:** The population that commits sexual offenses is extremely heterogeneous. Since there is no explicit profile to describe the juvenile sexual offender, initial and ongoing assessments are prerequisites for determining individual treatment needs.
- **Address "Offense Antecedents":** Each sex offender needs to: a) accept responsibility for the offenses in which he has been involved and b) have an understanding of the sequence of thoughts, feelings, events, circumstances, and arousal stimuli that make up his "offense syndrome" that precedes his involvement in sexually aggressive behaviors. These are called variously "links in the offense chain of events," "offense antecedents," or "offense precursors." Given the tendency of sex offenders to deny, minimize, rationalize, or lie about their sexually assaultive behaviors, getting them to own and accept responsibility for their acts is one of the first elements in the treatment agenda.
- **Interrupt Cycle of Offending:** Each sex offender needs to learn how to: a) intervene in or break into his offense pattern at its very first sign and b) call upon the appropriate methods, tools, or procedures he has learned in order to suppress, control, manage, and stop the behavior. The first step in breaking into the offense pattern is to recognize the earliest link in the chain of thoughts, feelings, and events that lead to offending.
- **Re-education / Re-socialization:** Each sex offender needs to engage in a re-education and re-socialization process in order to: a) replace antisocial thoughts and behaviors with prosocial ones; b) acquire a positive self-concept and new attitudes and expectations for himself, and c) learn new social and sexual skills to help

cultivate positive, satisfying, pleasurable, and nonthreatening relationships with others.

- **Test New Skills:** Each high-risk, residential sex offender needs a prolonged period during his treatment when he can begin to test safely his newly acquired insights and control mechanisms in the community, without the potential for affronting or harming members of the wider community.
- **Aftercare / Treatment Follow-up:** Each sex offender needs access to a post-treatment group for assistance in maintaining a safe lifestyle. Most programs provide some kind of therapeutic support for the client after he has graduated from the program. At least, there is usually a hotline, while others may permit the graduate to attend his former group or make provisions for him to meet with the program therapist on an individual basis (Knopp, 1985: 19-25).

Treatment Modalities

The treatment modality recommended most often for juvenile sexual offenders is a peer based group consisting of sexually offending peers. In fact, most current juvenile sexual offender treatment programs focus on the group as the central treatment modality with other treatment modalities as adjuncts (Utah Report, 1989; Oregon Report, 1986; Knopp, 1982; National Task Force, 1988; PREAP Survey, 1990). Group treatment requires that the offender learn how to interact with peers in an appropriate manner and provides a structured format for closely guiding offenders through the therapeutic process (Ross, 1987: 3). Exceptions to the peer group recommendation should occur only when the offender is demonstrably unable to function in a group setting because of language barriers, severe psychiatric conditions, or severe intellectual deficiencies (National Task Force, 1988: 22).

Because of the complex, multi-dimensional nature of adolescent sexual offending the use of adjunct treatment modalities should be individualized and based on careful assessments of the juvenile's needs. Adjunct modalities include: individual therapy; family therapy; physiological arousal assessment and treatment; biomedical interventions; substance abuse intervention; sex education; educational assessment for remedial or special education referrals; social skills training; assertiveness training; anger management; victimization issues; counseling for parental loss issues; cognitive restructuring; values clarification; and stress management.

Treatment Effectiveness

There is no fool-proof way to tell whether or not treatment for juvenile sexual offenders has been successful. Until valid measures of treatment success have been developed through careful longitudinal research, it will not be possible to accurately identify and validate those treatment variables that will allow adolescent sexual offenders to control their sexually offensive behaviors. Still, adolescent sex offender treatment specialists are likely to agree that early intervention is critical to the cessation of sexually compulsive behavior. Furthermore, they are likely to argue that offenders exposed to programs that provide the interpersonal skills and techniques required to recognize and manage their sexually aggressive behaviors have a much better chance of controlling their behavior than those who have not had such treatment (Knopp, 1985: 26).

Treatment progress is determined by the accomplishment of specified goals and objectives, cooperation during treatment, demonstration of self-control, demonstrable changes in thinking patterns, and positive changes in personal behavior over time. The passage of time or physical attendance in treatment is not, by itself, an indication of progress. Treatment progress can only be established by objectively measurable indicators, including:

- Acknowledgement of responsibility for offense without denial, minimization, or projection of blame.
- Behavioral indicators of work toward treatment goals.
- Ability to recognize factors contributing to offending cycle.
- Positive changes in factors contributing to offending cycle.
- Demonstrated capacity for victim empathy.
- Improvement in self-esteem.
- Increases in positive sexuality.
- Pro-social interactions.
- Positive family interactions.
- Openness in examining thoughts, fantasies, and behavior.
- Ability to counter irrational thinking and thinking errors.
- Ability to interrupt offending cycle and seek help.

- Increase in assertiveness and communication skills.
- Resolution of personal victimization or loss issues.
- Ability to experience pleasure in normal activities (National Task Force, 1988: 28).

Treatment for adolescent sexual offenders requires careful attention to treatment follow-up and aftercare. The final and best test of the success of treatment is the offender's ability to control his sexually offending behavior in the community after treatment. However, one should be careful when determining that an offender has "completed" treatment. The careless determination that an offender has "completed" his treatment may contribute to his ability to deny that he is still at risk of re-offending. Aftercare provides a therapeutic link between the treatment mode and independent living. A gradual diminishment of official or clinical supervision allows for clinical feedback of progress, helps the offender to gain confidence in exercising new pro-social skills, and helps to maintain community safety by providing continued vigilance over the sexual behavior of the offender.

Availability of Treatment

A survey of juvenile sex offender programs and treatment providers conducted by the Safer Society Press in 1990 identified 626 treatment programs and service providers specializing in juvenile sex offenders (Knopp, 1990). This survey revealed, among other things, that 43% of all of the services identified were located in 7 states: California (73); Washington (43); Ohio (40); New York (31); Massachusetts (30); Michigan (26); and Oregon (26). Representing the other end of the continuum were three states with only one program identified (New Mexico, Oklahoma, and West Virginia) and three states with no programs identified (Alabama, Arkansas, and Mississippi).

Most of the sexual offender treatment programs identified in the survey were Community-Based (outpatient) Services -78% of all programs. Of the programs identified as Community-Based, 41% were associated with mental health services; 52% were private service providers; 6% were court related-services; and 1% were community-based prison-related services. Residential treatment services accounted for 22% of the treatment services were residential programs. Of those, 29% were

located in secure residential facilities, 26% were located in mental health facilities; 39% were located in private facilities; 6% were located in court-related facilities.

The Safer Society survey revealed that peer-group treatment is the preferred juvenile sex-offender treatment method in 84% of the identified service providers. The availability of other treatment modalities identified by this survey include:

- **Family Therapy:** Available in all but two states (Oklahoma and New Mexico) with identified treatment services and included in 92% of all of the sex offender specific services identified.
- **Thinking Errors Approach:** Used in 61% of the identified services representing 43 states. 33% of the services using this approach are located in four states - California, Ohio, Oregon, and Washington.
- **Behavioral Methods:** Used in 45 states and 65% of the programs identified. One quarter of the services using this method are located in three states - California, Oregon, Washington.
- **Aversive Conditioning:** Represented in 24% of the treatment programs represented in the survey. Used in 33 states; 19% of all programs using aversive conditioning are in Washington state.
- **The Penile Transducer:** Used in 32 states representing 21% of the identified services. 32% of the programs using this method are in California.
- **Depo-Provera:** A biomedical component which lowers sexual drive and available in 20 states but in only 7% of the agencies identified.

The Safer Society survey also identified programs providing treatment of special juvenile sex offender populations, including low-functioning / developmentally-disabled sex offenders. Services to juvenile low functioning or developmentally disabled sex offenders were identified in 44 states and the District of Columbia. Forty-five percent of all programs identified provided some form of treatment for this specialized sub-population and 34% of those are located in five states - California (23), Washington (21), Ohio (19), Massachusetts (17), Oregon (15). Services to juvenile female sex offenders were identified in 43 states and the District of Columbia. Sixty-two percent of all services identified provided some form of specialized treatment for female sex offenders and 47% of those programs are located in eight states - California (53), Washington (35), Ohio (21), Florida (18), Texas (18), New York (18), Oregon (18), and Massachusetts (18).

Treatment Shortfalls - Gaps in Services

There are chronic shortfalls in the provision of treatment to juvenile sexual offenders other than the lack of treatment resources required. These include: 1) disparity of resources (i.e.: urban vs rural); 2) inappropriate placement decisions; 3) lack of treatment resources to address the needs of special populations (i.e.: sexually reactive children under 12, intellectually deficient, female offenders); 4) continued use of standard treatment modalities when sex offender specific treatment is indicated; 5) dearth of treatment specialists/clinicians with juvenile sex offender specific skills; 6) lack of adequate funding for training court staff, treatment providers and juvenile court judges in sex offense specific issues; 7) failure of treatment programs to employ the full range of treatment modalities available for juvenile sexual offenders; 8) failure to include the family in treatment; and 9) failure to use court sanctions to give muscle to treatment requirements (Utah Task Force Report, 1990: 25).

An adequate juvenile court response to juvenile sexual offenders requires a thorough and honest assessment of the treatment resources available in the community to meet the specific needs of individual offenders. Because the needs of juvenile sexual offenders are so very particularized, communities should strive to put in place a continuum of services that will meet those needs as required. When gaps in the continuum of resources are identified, they must be filled. If existing fiscal resources do not allow a direct purchase of the required resources, innovation, creativity and flexibility should be exercised to overcome the deficiency. Courts faced with inadequate sexual abuse treatment service delivery systems should:

- Take an accounting of all available existing treatment resources;
- Work to develop, improve, coordinate, and expand existing resources;
- Record treatment shortcomings to document the need for additional services;
- Strive to fill the gaps in treatment services available to the community.

Placement decisions should always address and consider issues of community safety. If victim safety and treatment options are not compatible and cannot be reconciled, victim safety should be given highest priority. Similarly, if treatment needs conflict with community

safety, the needs of the community must take precedence. Placement decisions should also account for the safety of the offender who may be vulnerable to victimization himself or face retaliation in the family, community, or placement (National Task Force, 1988: 23).

JUVENILE COURT INTERVENTION OPTIONS FOR ADOLESCENT SEXUAL OFFENDERS

In the fall of 1990, National Center for Juvenile Justice conducted a survey of 592 juvenile probation departments nationally to collect information on the placement options and treatment programs available to the courts to address juvenile sexual offenders. Specifically, the survey sought information on: 1) the adequacy of disposition options for sexual offenders; 2) perceived gaps in services to address sexual offenses; 3) the array of disposition options available to juvenile courts. The survey also asked respondents to identify programs they believed were "particularly effective" in addressing the problem of sexual offenses committed by juveniles.

Of the 244 agencies responding to the survey, only 25% reported that they had adequate disposition and treatment options specifically designed for juvenile sexual offenders. Seven of the respondents indicated that juvenile sex offenders were not a significant problem for them and, as a result, they did not need sex offender specific programs. Given the opportunity to list the types of programs needed to adequately address juvenile sexual offenders in their areas, respondents provided an array of services and programs ranging from community based treatment programs to secure correctional care. The need for out-patient treatment programs was mentioned the most by respondents (90 mentions). In-patient treatment programming was the second most mentioned need with 79 mentions. Other service needs included (number of times mentioned in parentheses): group homes (20); secure residential treatment (20); therapy (18); day treatment (16); community based treatment (19); diagnosis and evaluation services (15); juvenile intensive probation services (5); continuum of care (5); and foster care services (6). The survey also elicited at least one mention for each of the following services: family programming; home detention; aftercare; residential treatment for young offenders; secure correctional care; shelter care; and multilingual programs.

In spite of the fact that most of the agencies responding to our survey were dissatisfied with the options available to them, over 150 of the respondents submitted information on programs they believed to be "particularly effective" in addressing the problem of sexual offenses committed by juveniles. In all, the survey revealed over

200 separate juvenile sexual offender programs recommended by juvenile court agencies. The Center followed-up on these recommendations with another survey addressing the characteristics of these programs and received 70 responses, representing 30 states.

We have selected several of these programs for description in this report. The descriptions are offered for purposes illustrating different approaches to addressing the problem of juvenile sexual offenders. No attempt was made to evaluate the relative effectiveness of any of the programs to follow. In fact, the programs were selected primarily because of the clarity of the descriptive materials they sent to the center. The programs described below include:

1. An out-patient sex offender treatment program in Akron, OH;
2. A staff-secured residential treatment program in Terre Haute, IN
3. A secure residential treatment program in Courtland, AL;
4. A secure corrections program in Brooktondale, NY;
5. A program offering a continuum of treatment environments in Phoenix, AZ
6. One juvenile court's response to sexual offenders in Allegheny, County, PA;

Akron Child Guidance Center Adolescent Male Sex Offender Treatment Program Akron Ohio

The Adolescent Male Sex Offender Treatment Program located in Akron, Ohio is a non-residential treatment program for male juvenile sexual offenders. The program utilizes cognitive behavioral, psycho-educational, and psycho-therapeutic approaches to treating juvenile sexual offenders. It is operated through a local mental health agency and offers a wide range of treatment services, including: adolescent groups, parent groups, anger management, sexual skills training, and cognitive restructuring.

The Adolescent Male Sex Offender Treatment Program is a component of the Akron Child Guidance Center. The program is committed to providing treatment to adolescent sexual offenders on an outpatient basis.

This commitment is consistent with the overall philosophy of the Child Guidance Center to deliver mental health services in the least restrictive environment. However, because of the potential threat posed by sexual offenders to the community, a great deal of emphasis is placed on rigorous assessments that can determine the level of risk to the community in attempting to treat the offender on an outpatient basis. Only those youths falling within an established acceptable range of risk are admitted into the program. The Center also recognizes the need to work cooperatively with other agencies with responsibilities for addressing sexual offending in the community. The Center has established relationships with law enforcement agencies, the juvenile court, and child services agencies.

The target population for this program is generally those offenders with an overall low to medium risk of re-offending as determined through formal assessment procedures. Currently, only males of pre-adolescent age and up are considered for the program. Assessment of prospective clients addresses their ability to:

- understand their problem behavior;
- recognize needs that are being satisfied by their sexually aggressive behavior;
- understand the seriousness of their behavior;
- recognize different manifestations of sexually aggressive behavior in their own actions;
- evaluate the relationship between their own victimization and their acting out;
- identify personal beliefs, attitudes, and rationalizations that prevent insight into their problems.

The specialized assessment of prospective clients determines:

- The general dangerousness regarding the nature of sexually aggressive behavior and the threat to the community and the victim.
- The estimated risk of repeating the sexually aggressive behavior;
- To determine the nature, extent, and seriousness of the sexually aggressive behavior problem;
- To evaluate the specific social, family, environmental, and behavioral treatment needs of the offender; and
- To provide a specific recommendation regarding the ideal course of intervention and treatment along with secondary recommendations.

The outpatient treatment of juvenile sex offenders occurs in three phases: 1) psycho-education; 2) weekly offense-specific group treatment with adjunctive family therapy; and 3) aftercare. The basic objective of the psycho-education curriculum is to increase awareness about the problem of sexual assault, the impact on the victim, and provide a preliminary orientation to sex offender treatment. The psycho-educational sequence is required for both both offenders and their parents and includes the following topics: 1) an introduction to sexual aggression; 2) the psychology of the sexual offender; 3) the victim; 4) human sexuality; 5) specialized sex offender treatment.

The therapy component of the program includes both offense specific group therapy and adjunctive family therapy. Offender groups normally consist of a maximum of six participants. Assignments to a group are made on the basis of age and/or maturity level. Groups are led by co-therapists, are generally thought to be long-term, and attempt to have offenders:

- fully admit the offense record and history;
- understand the connection between deviant sexual fantasies and sexually aggressive behavior;
- understand the impact on the victim and the victim's family;
- deal with their own victimization issues when relevant;
- attempt to make amends for sexual offenses; and
- prepare a written aftercare plan.

Family therapy is a critical component of the Outpatient Sex Offender Treatment Program and serves the following purposes: 1) helps assure that the proper level of supervision is being provided to the offender; 2) reinforces the importance of the offender's accountability to parents/guardians; 3) provides support to the offender for continuing in therapy; and 4) assures that parents participate with the offender in certain therapy assignments.

Following successful completion of the active group and family treatment components, offenders become eligible to enter the Aftercare phase of treatment. Aftercare is provided in recognition that offenders will likely need very long term support to keep themselves under control. This support is provided in the context of a

carefully monitored support group with a staff member of the program serving as a professional resource to the offenders.

Effectiveness of the Akron Child Center's Outpatient Sex Offender Treatment program is measured by the extent to which offenders are able to abstain from further sexual aggression on a long term basis.

For more information on the Akron Child Center's Outpatient Sex Offender Treatment contact Robert Bender, Director of Clinical Services at (216) 762-0591.

Gibault School for Boys Intensive Sexual Intervention Systems (ISIS) Unit Terre Haute, IN

The Intensive Sexual Intervention Systems Unit is a staff secured residential treatment program for up to 25 male juvenile sexual offenders between the ages of 10 and 17. The program utilizes primarily cognitive behavioral therapy and value-based behavior therapy for treating juvenile sexual offenders. This private not-for-profit school and residential facility offers a wide range of treatment services, including: family therapy, parent groups, basic education, biomedical interventions, anger management, sexual skills training, cognitive restructuring, and values management. The optimal length of treatment in this program is 18 months.

The Gibault School for Boys recognizes that specialized and intensive treatment is necessary to change the aberrant behavior of adolescent sex offenders. Through the staff secured ISIS unit, Gibault School provides adolescents who have complicated and aggravated sex offenses with separate and isolated educational, recreational and therapeutic programs on the Gibault School campus. The ISIS program is comprised of:

- **A Treatment System:** Eighteen hours of group therapy per week on issues dealing with sexuality and sex offenses and weekly individual counseling sessions dealing with all other problem areas of the sex offender.
- **A Behavior Management System:** Daily accumulation (or subtraction) of points, awarded during 50 specific point periods each day. Rewards are based on positive behavior.
- **An Education System:** Two self-contained lower level classroom divisions. one self-contained

classroom for upper level academic courses taught for high school credit. Individualized instruction for various academic levels within a single classroom.

ISIS relies upon a number of treatment and programmatic systems to help male adolescent sex offenders gain control over their behavior. The treatment system includes: 1) a diagnostic system to identify the offender's major problems; 2) an individualized treatment system to help the offender complete a series of activities and assignments specifically related to his set of problems; 3) a skill development system to train the offender in appropriate social behavior; 4) an elemental therapeutic system for offenders below average IQ, low verbal ability, or learning disability; 5) an advanced therapeutic system for offenders with above average IQ or high verbal ability; 6) a moral development system to help offenders address cognitive and value errors and to provide a guide for what offenders should do (not simply to tell them what they should avoid doing); 7) a behavior management system to help offenders develop control over their actions; 8) an intensive education system to help offenders progress in their academic studies and overcome special barriers; 10) a recreation system to enable offenders to learn to play by the rules and have fun without hurting others; 11) an aftercare system to guide the offender toward success in his family and community upon release; 12) a feedback system to keep the offender informed of his progress in treatment and in the treatment community; and 13) a sexuality education system to develop understanding of the nature of sexuality and of the consequences of sexual actions. ISIS also provides, as part of the total package, systems to facilitate discharge, address substance abuse issues, develop empathy, come to grips with their own history as victims, and develop life skills.

The Gibault School will accept referrals from licensed child-placing agencies, juvenile courts, state and local probation and welfare departments, the Indiana department of Education, or other similar agencies. To be accepted, boys must have an IQ of at least 75 and be physically able to participate in the recreation program. The youth must not suffer from severe emotional disturbances that would require extensive psychiatric treatment. Likewise, the program will not admit youths requiring constant medical supervision for a serious chronic health problem.

For more information on the Gibault School for Boys Intensive Sexual Intervention Systems (ISIS) Unit contact Michael T McCrocklin, Ph.D., Director of ISIS at (812) 299-1156.

Three Springs Residential Treatment Center Courtland, AL

The Three Springs Residential Treatment Center is a secure residential treatment program for up to 30 male juvenile sexual offenders between the ages of 11 and 17. The program utilizes cognitive behavioral therapy and reality based behavior therapy for treating juvenile sexual offenders. This private residential facility offers a wide range of treatment services, including: individual therapy, family therapy, adolescent groups, parent groups, alcohol and drug counseling, basic education, biomedical interventions, anger management, sexual skills training, victims issues education, cognitive restructuring, stress management techniques, and values management. The optimal length of treatment in this program is 18 months.

Due to a dramatic increase in the demand for secure residential treatment spaces for juvenile sexual offenders the Three Springs Residential Treatment Center converted a vacant medical-surgical facility in Courtland, AL to a secure, locked facility for juvenile sexual offenders. The Three Springs sexual offender treatment program consists of four phases:

- **Assessment:** Within 10 days of admission each adolescent has an individualized treatment plan developed using a variety of assessment instruments selected from nursing, social work, psychiatric, recreational therapy, and educational programs.
- **Education:** The on-campus school provides classroom instruction based on the student's readiness and abilities. The low teacher to pupil ratio allows for individualized attention for students with special educational needs.
- **Family Therapy:** Family therapy provides a family based forum for addressing the myriad of feelings and issues brought to the fore by the clients sexually offending behavior.
- **Life Skills:** The purpose of the life skills group is to increase coping skills to help the resident better manage himself and his environment. This component addresses the following issues: communication with parents and peers;

assertiveness training; decision making skills; anger management, developing a positive sexual identity.

The Three Springs sex offender treatment program has identified several objectives for treatment. Members of the sexual offender group must:

- **Confront the Denial or Minimization of the Offense:** The goal is to clearly identify the offense/problem behavior so that the resident can assume responsibility for these behaviors.
- **Identify the Pattern or Cycle of the Offensive Behavior:** In order to prevent further offending behaviors, the offender must understand the cognitive, behavioral, situational, and psychological events which contributed to the offense. Residents are expected to identify triggers to the offensive behavior; learn and to practice behavioral alternatives that will interrupt the offending cycle. Residents are also expected to maintain a journal and complete offense related homework assignments (ie: writing about the offense scenario in terms of feelings, behaviors, and thoughts).
- **Establish Victim Empathy:** The offense is personalized by having offenders refer to victims by name and having the offender play the victim's role and experiencing the victim's trauma.
- **Undergo Cognitive Restructuring:** Used to combat the irrational thinking with rational thoughts which produce the desired internal feeling without exploiting others.
- **Address Issues of Family Dysfunction:** Left untreated, existing family dysfunctions can undermine the treatment process. Family therapy and parent's groups work to create an environment which supports the treatment process.
- **Address Deviant Arousal Patterns:** In some cases, arousal comes from fantasy material unrelated to the actual sexual behavior or specific victim. An important treatment goal is to foster non-exploitive arousal patterns.
- **Address Impulse Control Issues:** Combinations of Cognitive approaches and relaxation techniques are used to foster greater tolerance of frustration.
- **Sex Education and Positive Sexuality Training:** The goal in this component of the treatment program is to help the offender develop appropriate sexual expectations and interests and to improve his socialization skills.

Residents of the sex offender treatment group are subject to a level and point system to help them assume

responsibility for and accept the consequences of their behavior while in the treatment center. This highly structured system provides external structure for the offender until he progresses in treatment to the point that he can demonstrate the ability to internally control his behavior. In fact, the ultimate goal of Three Springs Residential Treatment Center Sexual Offender Program is to change the offender's thinking and behavior to the extent that repeat offending does not occur upon release.

For more information on the Three Springs Residential Treatment Center Sexual Offender Program contact Beverly McLemore, Administrator or Pam Cook, Program Director at (205) 637-2199.

Austin MacCormick Center Adolescent Sex Offender Treatment Project Brooktondale, NY

The Austin MacCormick Center is a 52 bed, secure residential correctional facility operated by New York State's Division for Youth. The Center holds felony offenders between the ages of 14 and 21. The Adolescent Sex Offender Project is a secure residential treatment program within the Center. Although the Project is designed to be flexible enough to handle as many sexual offenders as the Center can provide, the optimal number of clients is 16 to 24. The program utilizes cognitive behavioral therapy and psycho-educational based behavior therapy for treating juvenile sexual offenders. This facility offers a wide range of treatment services, including: individual therapy, adolescent groups, alcohol and drug counseling, basic education, anger management, sexual skills training, victims issues education, cognitive restructuring, stress management techniques, and values management, structured learning, parenting skills training, and social skills training. The optimal length of treatment in this program is 36 months.

It is the mission of the Austin MacCormick Center to provide each youth with the necessary opportunities to prepare him for successful participation as a productive member of his community. The following serve as the conceptual foundation for the Center's operations:

- No single program component operates in isolation. Any specialized program and/or counseling model is integrated with the focus and direction of all interventions.

- Specialized therapeutic interventions, whether they address substance abuse, deviant sexual behavior or anti-social behavior, are dependent on each youth's ability and readiness to participate.
- A variety of classification systems within institutions can be compatible with providing services to "special populations," given adequate resources, training, and clarity of treatment goals.

Through an educational orientation, the entire milieu of the MacCormick Center becomes both a means and a context for personal growth and change. MacCormick stresses learning through daily living experiences that are carefully planned and guided by the staff. The acquisition of specific competencies, including skills, behaviors, self-image and values, provides each youth with the resources necessary to achieve success.

The implementation of specialized counseling is dependent on the youth's ability to articulate problems, participate in a group discussion, and engage in problem-solving and decision-making processes. Because many of the youths held at the MacCormick Center lack these prerequisite skills and because of the wide diversity of the resident population, the Center does not segregate youths by designated problem areas. Rather, it relies on a method of carefully selecting residents for specialized counseling programs and pulling them out from the general population for participation in groups and individual counseling. By utilizing the "pull-out" strategy for specialized counseling programs, the Center is better able to "shape" the size and characteristics of the treatment groups.

The Adolescent Sex Offender Treatment Project relies on a small cluster (4 - 6 members) approach to this type of group work. The "intimacy of content" is directly related to group size - smaller groups allow for greater individual disclosure and participation in discussion. The sex offender treatment program has been divided into eight component parts including: 1) Individual History/Assessment; 2) Thinking Errors; 3) Victim Awareness; 4) Deviant Sexual Arousal Patterns; 5) Family Issues; 6) Sex Education; 7) Hetero-social Skills; and 8) Relapse Prevention.

These components can be used as a series or independently to address specific issues. Groups are held once a week for one-and-a-half to two hours. Individual sessions are held on a weekly basis to allow the treatment

team to focus on particular issues or individual areas of concern. Participants are given homework to help expand the scope of their involvement in the program. Once a youth has finished all eight components of the program, individual progress is assessed by having the youth participate in the assessment component again.

For more information on the Austin MacCormick Center's Adolescent Sex Offender Treatment Project, contact Dr. Susan Yeres, Assistant Director at (607) 539-7121.

Phoenix Memorial Hospital Adolescent Sexuality and Addictions Program Phoenix, AZ

The Adolescent Sexuality and Addictions Program provides a continuum of treatment modalities that range from secure in-patient programs to non-secure residential programs. The program addresses the needs of both adult and juvenile sexual offenders as well as survivors of sexual abuse. This local mental health agency treats both male and female offenders between the ages of 10 and 17. The program utilizes cognitive behavioral therapy, psycho-educational therapy, relapse prevention, and arousal conditioning for treating juvenile sexual offenders. This facility offers a wide range of treatment services, including: individual therapy, family therapy, adolescent groups, parent groups, alcohol and drug counseling, basic education, biomedical interventions, anger management, sexual skills training, victims issues education, cognitive restructuring, stress management techniques, and values management. The optimal length of treatment in this program is 12 months.

The Phoenix Memorial Hospital's Sexuality and Addiction Program offers the least restrictive environment possible for a particular client and includes the whole spectrum of treatment options. The program is highly structured and designed to assist adolescents toward resolution of life problems associated with sexual victimization, sexual misbehavior, and/or chemical dependency, while simultaneously identifying a life style that is desirable for habituation. Services are available 24 hours a day, 7 days a week. The goals of the LRE program are to:

- protect victims and the community from further victimization by offenders;

- reintegrate clients into the community without re-involvement in socially unacceptable or delinquent/criminal behaviors;
- assist in identification and evaluation of sex offenders;
- assist the adolescent survivor of sexual abuse in understanding his/her victimization and promoting an alternative life style that will free the adolescent from continued victimization by self and others;
- identify and address treatment goals relevant to behavior change and community reintegration; and
- maintain a treatment milieu that provides: a tolerant and non-threatening confrontation of problematic behaviors, skills or issues; education and training to resolve the problematic behaviors/issues; coordination and assistance in the development of support systems; individualized treatment plans; an environment which is "safe" and conducive to treatment; address cognitive errors, skill deficiencies, and/or socially unacceptable or deviant behaviors; and the least restrictive environment possible.

Treatment and assessment in the Sexuality and Addiction Program are provided by a variety of health care professionals including: psychiatrists, psychologists, social workers/counselors, registered nurses, certified teacher, certified recreational therapists, physicians, polygraphers, and paraprofessionals. The program is a multidisciplinary intervention that attends to diminishing the symptomology and affords resolution of presenting problems. The intervention may consist of one or more modalities ranging from psycho-education to art therapy to aftercare.

All adolescents are admitted to the assessment phase to determine baseline data, amenability to treatment, reliability as a self reporter, risks for future acts of inappropriate behavior, psychopathology, continuum of sexual interests, habituation of sexual deviant patterns, history of sexual victimization and resulting outlets. Following the assessment, staff meet to discuss the results of the evaluation and to make recommendations. If accepted into the program, adolescent offenders are placed in one of the following treatment levels: Level B - High risk; Level C - Moderate Risk; Level D - Low risk; Level E - Outpatient day Treatment; and Outpatient Counseling.

Movement to the different levels of treatment is determined by the adolescent's investment in treatment and achieving treatment goals. The clinical polygraph, plethysmograph, MMPI, MSI, cardsort, urine testing, understanding of the cycle of misbehavior, personalization of the cycle of misbehavior, group participation, and development of an alert list are used to determine advancement to various levels of the program. As progress occurs, treatment becomes less intensive, less restrictive, and less expensive.

For more information on the Adolescent Sexuality and Addiction Program contact Robert Emerick at (602) 238-3585.

Court of Common Pleas of Allegheny County Family Division - Juvenile Section Special Services Unit Pittsburgh, PA

The Allegheny County Juvenile Court's Special Services Unit (SSU) was designed to provide probationary supervision and specialized treatment services for both institutionalized and non-institutionalized juvenile sex offenders.

The SSU was developed in 1985 in response to an increasing number of sex offense cases being referred to the court, and to provide a missing link in the existing network of programs and services available for this specialized offender population. The SSU targets offenders who were permitted to remain in their own homes under Probation Department supervision as well as offenders for whom no specialized aftercare services are available upon release from secure residential care.

The SSU consists of one supervisor and four probation officers who are paired in two male/female teams. One team specializes in aftercare services while the other team is responsible for supervision and treatment of offenders on probation. The objectives of the SSU are twofold: 1.) to demonstrate the viability of non-residential treatment for juvenile sexual offenders; and 2.) to prevent recidivism by effectively treating and managing their sexually aggressive behavior. The program emphasizes community safety and, in fact, is designed to provide high intensity supervision of offenders.

SSU staff are carefully selected on the basis of requisite personal qualities and professional skills. These

staff are also subject to a rigorous in service training regimen addressing the latest theories and the most advanced therapeutic techniques available. The SSU program is composed of the following operational components:

- **Evaluation Component:** The SSU has developed and utilizes a complete comprehensive evaluation for every offender involved in the program or otherwise referred for evaluation. This tool assesses risk factors, identifies offender typologies, determines appropriate treatment environments, identifies specific treatment goals, and determines the degree of services indicated.
- **Institutional/Aftercare Component(I/A):** The I/A team works with sex offenders while they are in residential placement and after they are released in the community. The I/A probation officers work closely with the offender, his family, the therapeutic community. They also coordinate other services, such as mental health or substance abuse counseling.
- **Non-residential Component:** Treatment of offenders in the community involves regular contact with the SSU team three times each week, including an offenders group. The group is highly structured and combines the use of the sex offender educational curriculum and offender journals and homework.
- **Educational Curriculum:** The S.S.U. utilizes a comprehensive educational curriculum providing offenders and their parents with fundamental knowledge of human sexuality, relationships, feelings, stress, sex offender treatment goals, and sex offender myths. The curriculum provides a reality-based view of sex offender treatment issues.

The SSU has articulated several treatment goals for offenders assigned to this unit. Offenders are to:

- learn to accept responsibility for their behavior;
- begin to become more aware of their own feelings;
- gain awareness for the feelings of others;
- learn appropriate ways of expressing human sexuality;
- learn how the offender's sexually inappropriate behavior victimizes others and to explore the offender's victimization as well; and
- learn appropriate ways of dealing with feelings of powerlessness, and to learn how to use power in a positive manner.

The offender's progress in the program is determined on the basis of his acceptance and cooperation with his individual offender treatment program and his understanding of the treatment goals listed above. The offender must also develop and demonstrate competency in adhering to a solid personal daily living plan designed to eliminate further offenses. Offender's must also demonstrate a sincere expression of remorse for the victim(s) of his sexual aggression.

For more information on Allegheny County's Special Services Unit contact Rosemary H. Kuzmic, SSU supervisor at (412) 321-0365.

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