

Children and young people with harmful sexual behaviours: First analysis of data from a Scottish sample

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Abstract *Despite a growing awareness and acknowledgement of the incidence of sexually harmful behaviour by children and young people, research on this group remains limited. A number of recent publications have reviewed UK systems and practice and suggest that the issue is better appreciated than a decade ago. To date, however, there is no published information on this group in a Scottish context. As a first step in addressing this lack of empirical data, a joint exercise was conducted between the Criminal Justice Social Work Development Centre for Scotland and a number of specialist services for children and young people involved in harmful sexual behaviour to develop a picture of this group. Data on 189 such individuals were collected from cases active during 2004. This forms part of an ongoing data collection process, which is intended to provide practice relevant information and contribute to the development of services and interventions for this client group.*

Keywords *Harmful sexual behaviours; sexual offences; young offenders; children and young people in trouble*

Introduction

In the last 15 years there has been growing awareness and acknowledgement of the incidence of sexually harmful behaviour by children and young people. Researchers have estimated that between a third and a quarter of child sexual abuse is committed by young people under 18 years. The 2004 criminal statistics for England and Wales (Home Office, 2005) showed that of the 6,400 individuals cautioned for or found guilty of sexual offences approximately 17% were between 10 and 17 years of age. Of the 1,600 or so offenders cautioned, the vast majority of whom were male, around 19% were aged 12–14 years and 13% were aged 15–17.

In contrast to adult sex offenders, there is still relatively little literature on children with harmful sexual behaviours. Also, much of the work that can be found tends to focus on young people dealt within a judicial or criminal context (Hagan, Gust-Brey, Cho & Dow, 2001; Långström, 2001; Righthand & Welch, 2001; Snyder, 2000). Criminal statistics refer only to

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those over the age of criminal responsibility, which varies greatly between jurisdictions, and records only reported offences. As a consequence, research based on crime statistics is likely to reveal only a small proportion of actual incidence and the characteristics of the children and young people involved. There is subsequently little information available on those dealt with in a non-criminal context.

The age of criminal responsibility in Scotland (age 8 years) is one of the lowest in developed countries, which means that the legal context for decision-making in much of the literature is different from that in Scotland. While children and young people who commit serious offences or present harmful and dangerous behaviour may be dealt with through the courts in Scotland, almost all of those under 16 are dealt with through Scotland's system of Children's Hearings, which takes the format of a trained lay tribunal charged to act in the best interests of the child (Scottish Executive, 2003).

In addition, variation between studies in terms of rationale, terminology, assessment classification and sample sizes creates problems in generalizing or drawing comparisons from existing literature. It is therefore difficult to say how unique or distinctive this group is in comparison to the wider population of young offenders (van Wijk, van Horn, Bullens, Bijleveld & Doreleijers, 2005) or young people in general.

Given the potential for harm that some of these children and young people can present, the public fear and attention that serious crime attracts (see, for example, the Colyn Evans case in Scotland: SWIA, 2005) and the needs and vulnerabilities that many of these children appear to have (Hackett, 2004), there is an urgent need to examine this group in more detail to assist the development of processes and services for responding effectively (Lambie & Stewart, 2003; Seabloom W, Seabloom M, Seabloom E, Barron & Hendrickson, 2003).

A number of recent publications have reviewed UK systems and practice, and suggest that the problem of sexual abuse by children is better appreciated both by the professional community and by government than a decade ago (Hackett, Masson & Phillips, 2003; Hackett, 2004). However, to date no examination has been made of these children in a Scottish context. To begin this process and attempt to develop a profile of this group, a data collection exercise was undertaken to gather consistent information from specialist sexual behaviour services for children and young people in Scotland. What follows is an account of work in progress and provides brief summary of some of the main findings from this exercise (full findings from the exercise, along with the data collection instrument can be found on the website of the Criminal Justice Social Work Development Centre for Scotland at www.cjsw.ac.uk).

Method

Procedure

The Criminal Justice Social Work Development Centre for Scotland "the Centre"), based at the University of Edinburgh, hosts a number of "Champions Groups", which are national development groups with the purpose of promoting best practice within a wide range of fields including adult sex offenders, women offenders, prison throughcare, youth justice and children with harmful sexual behaviours. These Champions Groups have a core membership representing local authorities and voluntary organizations covering all of Scotland.

The Group concerned with children with harmful sexual behaviours was established in July 2003, with part of its remit to identify a profile of these children in Scotland. To begin this process, a "client monitoring" form was developed in collaboration with practitioners to collect standard information on children and young people with harmful sexual behaviours referred to the specialist services represented on the development group. The client

monitoring form is comprised of 50 questions, in multiple-choice/tick-box format with free text space for “other” responses where required, and a free text space for comments at the end of the form. It includes five sections. The first section covers general information on the client, such as date of birth, details of any involvement with social work services (other than that for problem sexual behaviour), accommodation status and education/employment status. The second section gathers data on referral to the specialist service (e.g. referral date and source), while the third covers factors related to risk, such as assessment tools used, level of risk awareness, legal status at referral and any previous referral or convictions. The fourth section covers trauma and needs relevant to the client, such as abuse, neglect, exposure to inappropriate environments, concerning non-sexual behaviours and current living environment. The fifth and final section relates to the sexual behaviour displayed by the client, including the nature of this behaviour, location at which it took place and victim/incident details.

The monitoring form was also intended to be used as a practice tool to assist in gathering relevant data on individual children for assessment and planning purposes that could be collated in one place. The pilot data sweep collected information on live cases between 1 January 2004 and 31 December 2004. A total of six Champions Group members submitted data, covering eight of the 16 postcode areas in Scotland: a geographical area stretching from the Scottish Highlands through to Dumfries and Galloway and including six local authorities.

A total of 189 client-monitoring forms were submitted to the Centre for analysis by the deadline of 28 February 2005. As is to be expected in any pilot exercise of this type, it was clear that the form could be improved in a number of areas to promote the quality and clarity of the data collected. For example, where questions had not been answered, it would have been of use to include the options “unknown” and “not applicable”, so it would be clear why no response had been entered. These and other issues have been addressed, and a revised client monitoring form was made available for use from 1 January 2006. In the meantime a second data sweep, using the existing monitoring form and covering live cases between 1 January and 31 December 2005, is under way at the time of writing (March 2006), with 87 new cases already submitted to the Centre.

Subjects

Data were collected on 189 children and young people (“clients”) who had been referred to specialist sexual behaviour services in Scotland, and whose cases were live during 2004. They ranged in age from 5 to 20 years and, having been referred to the service, could be attending under compulsory measures or voluntarily (including those under the age of criminal responsibility). On consulting the Champions Group, it was established that older clients (over 18) were those whose cases had been active for some time, and were still in contact with services (as part of throughcare) due to particular vulnerabilities.

Findings

Client characteristics

Sex. The highest proportion (94%) of clients was male, with only 6% (11 clients) being female. There were some indications of differences between males and females in this group, but the low number of females prevents any firm conclusions being drawn from these differences. Nevertheless, some of these differences are worth noting. For example, female

clients were much more likely to have been brought to the attention of social work services (e.g. for care or protection issues), with 81% falling into this category compared to 53% of males. Similarly, females were less likely to be residing with their parents at time of referral (18%) than were males (49%). The early care-giving environment was much more likely to have been recorded as “insecure” for females (82%) than males (47%). Female clients appeared more likely to have experienced emotional abuse (73%) and neglect (82%) than males (49% and 43%, respectively). It was also more likely for female clients to have been subject of some form of statutory supervision requirement (73%) than male clients (39%); in the case of female clients, all the supervision requirements were related to child welfare issues.

Age. Client dates of birth were not commonly recorded on the monitoring form, due to concerns over confidentiality; however, in 171 of the 189 forms submitted it was possible to approximate the age of the client at January 2005 from other information. As stated above, client ages ranged from 5 to 20 years old, with a mean age of 14.5.

Age at referral. It was possible to establish the age at referral to the harmful sexual behaviour service in only 93 cases; this ranged from 9 to 17 years and therefore did not include any of the younger children in the full sample. Half (51%) were referred between the ages of 13 and 15, while 30% were referred between the ages of 9 and 12. The remaining 19% were referred at age 16 or 17.

Age at first contact with social work services. The clients’ age at first contact with social work services was recorded in 168 cases. Over one-quarter (27%) had their first contact with social work between the ages of 8 and 12, while a further 21% had their first contact between the ages of 13 and 15. Overall, those aged 7 years or under at their first contact with social work comprised almost half (48%) of those cases where this information was available. Children aged 7 and under at their first contact with social work were more likely than older children to have come to the attention of social work services for child protection or care issues, while those aged 16 and over were most likely to have come to the attention of social work for reasons of offending.

Involvement with social work services

It was recorded that 50% of clients had had previous involvement with social work services, while 65% were currently involved with such services other than those related to harmful sexual behaviour. The latter figure included 72 clients with previous service involvement—59% of those with current service involvement. It was also recorded that 30% of all clients in the sample had been placed formally onto the Child Protection register at some point during their contact with social work services. The data collection instrument did not allow for recording of the reasons a child had been placed on the Child Protection register.

Developmental impediments

Half the sample could be considered to have some type of impediment to normal development; for example, one-third (32%) had some kind of learning difficulty, while 15% of clients were recorded as having attention deficit hyperactivity disorder (ADHD); a small proportion of the sample (5%) were recorded as having both a learning difficulty and ADHD. Given that the sample was split evenly between those having some kind of impediment to normal development and those not, it was logical to attempt to make a

comparison across the two groups. However, while there were some notable differences between the two, given the complex nature of cause and effect in this context it would require a more in-depth form of analysis to consider the significance, if any, of these differences.

Home circumstances

The accommodation status of clients at the time of referral was recorded in 186 cases, split almost equally between those living with parents or family (48%) and those in non-family care (52%). Non-family care is defined as anything other than living with the natural parent(s) or close relatives. This is broadly in line with statistics for looked-after children at March 2004, where 43% of such children are recorded as living with parents and 14% with relatives or friends (Scottish Executive, 2005). The “non-family” category included 30 clients living in foster care; at 16% of this sample, this is lower than the figures for looked-after children as a whole, where 29% are recorded as being in foster care at March 2004 (Scottish Executive, 2005). It seems fair to state that a considerable proportion of those referred for harmful sexual behaviour had experienced some kind of significant disruption to “normal” family life.

Education

Education or employment status of the client at the time of referral was recorded in 184 cases, with almost half (49%) reported as attending mainstream schools. A further 16% were reported as attending specialist schools, with 8% at residential schools. Of the remaining 27%, 11% were in further/higher education or training, 8% were recorded as employed and 3% as unemployed. Related to this, around one-third (37%) of clients were reported as having a history of truancy and/or exclusion from school. In comparison to other UK studies, this figure would appear to fall somewhere in the middle ground, with Dolan, Holloway, Bailey & Kroll (1996) reporting truancy rates of 44%, while Manocha and Mezey (1998) report a truancy rate of only 14%.

Traumas and negative environmental experiences

In 139 cases, information on type of care-giving (related to attachment issues, e.g. Allen, Marsh, McFarland, McElhaney, Boykin, Land, Jodl & Peck, 2002; Bowlby, 1969) in the early years of a client's life was recorded. In two-thirds (68%) of these cases care-giving was reported as being insecure, with the remaining third (32%) being secure. Information on trauma issues and negative environmental experiences relevant to the client was also recorded; these are noted in Tables I and II. The categories included in these tables are not mutually exclusive and therefore the numbers stated do not add to 100%.

The findings here suggest that clients had frequently been subjected to multiple forms of trauma and negative environmental experiences. As indicated in Table I, only 23 clients (12%) had experienced just one form of the trauma; similarly, 12% of clients had no traumas recorded. The remaining 76% of clients had experienced two or more traumas, while 51% of clients overall had experienced four or more. At least 70% of clients in the sample had experienced some form of abuse or neglect. Similarly, Table II demonstrates that only 21 clients (11%) had experienced just one of these negative environmental conditions. However, 30% of clients had no negative environmental experiences recorded at all. The remaining 59% of clients had experienced two or more of these conditions.

Table I. *Trauma issues relevant to the client.*

Type of trauma	Number of clients	% of clients
Parental separation	102	54
Peer group difficulties	100	53
Emotional abuse	95	50
Parental neglect	85	45
Parental rejection	81	43
Domestic violence	75	40
Physical abuse	69	37
Suspected sexual abuse	59	31
Parental substance misuse	62	33
Sibling separation	61	32
Bullying	55	29
Numerous non-family placements	40	21
Known sexual abuse	35	19
Bereavement	29	15
<i>No traumas recorded</i>	23	12

Concerning non-sexual behaviours

With regard to non-sexual behaviours that could cause concern (see, for example, Dadds, Turner & McAloon, 2002; Duncan & Miller, 2002; Merz-Perez & Keide, 2004), overall recording of these was low, with incidents of animal cruelty, self-harm, substance misuse, fire-raising and inappropriate urination/defecation being recorded individually in less than 10% of cases. However, figures were higher with regard to perpetration of both interpersonal violence (23%) and bullying (23%).

Harmful sexual behaviour

Legal status at time of referral. The legal status at time of referral was recorded in 184 cases, with a little under half of clients (45%) recorded as engaging voluntarily with services or having no formal legal status. Fewer than 4% of clients had been subject to a court disposal, with a further 11% awaiting either a trial or a Children's Hearing. However, it was recorded that the Children's Hearing system was aware of clients in 49% of cases, although it is

Table II. *Negative environmental experiences relevant to the client.*

Type of environmental experience	Number of clients	% of clients
Poor emotional boundaries between adults/children	87	46
History of abuse/neglect	80	42
Poor physical boundaries between adults/children	64	34
Poor sexual boundaries between adults/children	62	33
Witness to aggression between adults	60	32
Lack of sexual education/punishment for anything sexual, etc.	60	32
Aggression between adults and children	55	29
Witness to substance misuse	52	28
Pornography not hidden from children	24	13
Inappropriate intimate care	20	11
Witness to sex being used for exchange	20	11
Children deliberately exposed to pornography	16	8
<i>No negative environmental experiences recorded</i>	56	30

impossible to state whether or not this was in relation to the harmful sexual behaviour, while 15 clients (8%) had been placed onto the sex offenders register. It was recorded that 16 clients (8%) had previous offences recorded in the adult criminal system, two of whom had previous sexual offences.

Sexually harmful behaviour by children and young people is likely to come to the attention of the Child Protection, Children's Hearing or Court systems at some time. However, the findings above imply that at any given moment, many of the children or young people were not subject to any robust system of monitoring or formal supervision. Those who had been, or were currently, subject to some type of statutory monitoring or supervision (i.e. had been subject to Child Protection registration, some form of supervision requirement or Sex Offender Registration) comprised only one-third (33%) of clients in the sample.

Age at which harmful sexual behaviour began. The age at which harmful sexual behaviour was estimated to have begun was recorded in 162 cases. Those whose harmful sexual behaviour was believed to have begun under the age of criminal responsibility in Scotland (seven or less) accounted for 22% of cases. In a further 39% of cases, clients' behaviour was reported to have begun between the ages of 8 and 12, 33% between ages 13 and 15 and the remaining 6% aged 16 or over.

Characteristics of harmful sexual behaviour. The type of sexual behaviour displayed by the child was recorded using the classification based upon Cavanagh-Johnson's continuum of sexual behaviour in children (Cavanagh-Johnson, 1998). This classification is not used by all practitioners, so information was recorded in 142 cases (75%) only, with 36 of these having a "don't know:" response. Cavanagh-Johnson recommends against using this classification for children over the age of 12, and so the findings here must be treated with some caution as at least 46 of the 142 clients for whom this information was recorded were aged 13 or over at the time of referral. In addition, more than one type of behaviour could be recorded for each client. The Cavanagh-Johnson classifications can be summarized as follows:

- *Reactive sexual behaviour:* applies to children who have been sexually abused and where their sexualized behaviour is a way of acting out confusion concerning their own experiences of being a victim of abuse.
- *Extensive mutual sexual behaviour:* refers to more pervasive and focused sexualized behaviours usually acted out on peers or siblings with persuasion but without force or coercion.
- *Abusive sexual behaviour:* refers to children whose sexual thoughts and actions are impulsive, compulsive and/or aggressive and who use coercion with victims

For the 106 cases (56%) where a sexual behaviour type(s) was recorded, the details can be found in Table III. This table is split into two to reflect those cases where more than one type of behaviour was recorded.

As indicated in Table III, the most common type of behaviour recorded involved an abusive element, with 60% exhibiting this type of behaviour. Those exhibiting reactive behaviour were only slightly less common (51%), with those exhibiting behaviour with a mutual element by far the least common (17%). Information was also recorded on facets of the sexual behaviour, these being the use of physical force, manipulation or threats. As with the Cavanagh-Johnson classifications above, multiple responses were allowed. This information was available in 107 cases (36 of which were not included in the Cavanagh-Johnson classification above), with the use of manipulation as part of the sexual behaviour appearing to

Table III. *Sexual behaviour types.*

Sexual behaviour type	Number of clients	% of those classified (n = 106)
Behaviour with an abusive element	64	60
Behaviour with a reactive element	54	51
Behaviour with a mutual element	18	17
Abusive behaviour only	46	43
Reactive behaviour only	30	28
Reactive and abusive behaviour	11	10
Reactive and mutual behaviour	7	7
All behaviours	6	6
Mutual behaviour only	5	5
Mutual and abusive behaviour	1	1
	106	

be the most common, being recorded in 70% of these cases. The use of physical force was recorded for 46% of the clients in this category, while 34% were reported as using threats.

How sexual behaviour was manifested. The ways in which problem sexual behaviour was manifested were recorded in 183 cases, falling into the categories of contact behaviour (47%), non-contact behaviour (13%) or both (40%). As can be seen in Table IV, the most common contact behaviours were touching others' genitals, either over (37%) or under (35%) clothing, while the most commonly recorded non-contact behaviour was sexually abusive language (30%). Multiple behaviours could be recorded for each client, so the categories are not mutually exclusive.

Victim characteristics

Victim sex. The sex of victims was recorded in 168 cases, with female victims being noted in 70% of these cases and male victims noted in 61% of cases. When examined in more depth, it was found that 38% of clients were reported as having female victims only and 29% as having male victims only; 32% of clients had both male and female victims. It was least common for male clients to have only male victims, while female clients were most likely to have only male victims. The likelihood of having only female victims, or both male and female victims, was similar in proportion for both male and female clients.

Number of incidents. The number of incidents in which the client had been involved was recorded, some as estimates. Of 160 cases, the highest proportion (31%) had been involved in one incident only and half of clients (51%) had been involved in three or less incidents. It was also recorded that 23% of clients had been involved in between five and 10 incidents, while 16% had been involved in 11 or more incidents. The number of victims each client was associated with was recorded in 157 cases, with the highest proportion (41%) recorded as having one victim only. Almost three-quarters of clients overall had three victims or less, while having four victims or more was recorded in 26% of cases.

Victim age. Victims' ages were recorded in 171 cases, with the highest proportion (51%) being aged between 6 and 10 years. Almost equal proportions of 11 to 13-year-olds (36%) and 3 to 5-year-olds (34%) were recorded as victims, with the lowest proportion (6%) being aged 2 or under. Given that details of individual victimization were not available, it is difficult to say

Table IV. Ways in which problem sexual behaviour was manifest.

	Number of clients	% of all (n = 183)
Contact behaviours		
Touching genitals over clothes	67	37
Touching genitals under clothes	64	35
Demanding to touch others	36	20
Simulating sex clothed	35	19
Actual oral sex	24	13
Sexualized talk/acts with known adults	19	10
Sexualized talk/acts with strangers	11	6
Simulating sex naked	11	6
Attempted oral sex	11	6
Attempted vaginal penetration	10	5
Attempted anal penetration	10	5
Actual anal penetration	10	5
Actual vaginal penetration	9	5
Other contact behaviours	25	14
Non-contact behaviours		
Abusive language	54	30
Exposure	44	24
Use of pornography	11	6
Telephone calls	6	3
Other non-contact behaviour	12	7

with any certainty what relationship exists, if any, between the age of the perpetrator and the age of the victim.

Relationship to victim. It was most likely that clients knew their victims, with this being recorded in 73% of the 171 cases where this information was available. Unknown victims were recorded in 15% of cases only. It was next most common for the victim to have been a sibling, with this being recorded in 27% of cases. It was relatively uncommon for clients to have recorded a mix of known and unknown victims, with this being recorded in only 5% of cases.

Location where inappropriate sexual behaviour occurred

The location where sexual behaviours were reported as taking place was recorded in 170 cases, again with multiple responses being possible. Incidents in the home (which could refer to residential care as well as the family home, an ambiguity being rectified for future data collection) were most common, being reported in 58% of cases, followed by incidents in the outside community (47%). Incidents at school (this could refer to residential schools, which conflicts with the “home” category, and is again an ambiguity being addressed) were reported in 29% of cases, with those occurring in a community facility recorded in 7% of cases. Incidents occurring at multiple locations were noted in 55 cases (32%), the most common cases being clients who exhibited harmful sexual behaviour both at home and in the community outside (9% of all 170 cases).

Discussion and conclusions

It should be noted that the sample size is relatively small, especially when comparisons are being made across different categories within the sample. Therefore, it is important to view any

conclusions drawn here with caution, as the details drawn out are intended as points for debate rather than definitive statements of interpretation. In addition, as little over half of the sample relates to clients from two sexual behaviour services, this may have skewed findings somewhat, although there is no way of knowing until more data is collected from across Scotland. As information on this client group is almost non-existent in Scotland, it is hoped that the exercise upon which this study is based will contribute to the development of both knowledge and practice in this area, particularly as the data collection continues and the sample size grows. In these preliminary stages, however, it is important to bear in mind the caveats stated here.

From the findings reported above and the full analysis of the data, it is very clear that those children coming into contact with services for harmful sexual behaviours in Scotland display a wide range of characteristics, backgrounds and behaviours. Due to the way in which data were recorded, it is not possible to draw any firm conclusions with regard to victims, but it is intended that this area will be explored in more depth as the study continues.

The evidence suggests that Scottish children and young people who display sexually harmful behaviour towards others may have suffered considerable disruption in their lives, have been exposed to violence within the family, may have witnessed or been subjected to physical or sexual assault, have problems with their educational development and may have committed other offences. Such young people are viewed in the Scottish system as children in need and some, in addition, are themselves deemed to be in need of protection. There were some indications that the harmful behaviour manifests differently between males and females. It was also clear that harmful sexual behaviour could emerge at almost any age.

In addition, the findings illustrate one of the many potential problems related to children with harmful sexual behaviour, that of early identification. While the findings here could imply that a small proportion of children who are abused and vulnerable may ultimately display harmful sexual behaviours, this will not be the case for the majority. In contrast, there would seem to be a number of older children whose harmful sexual behaviour could be described as appearing “out-of-the-blue” (e.g. no indication of a troubled background or prior contact with social work services) with the behaviour perhaps having more to do with a general pattern of offending, or the onset of adolescence, than any obvious trauma. In either case, it will be necessary for interventions related to harmful sexual behaviour to address the particular needs of each client group.

Much of the literature that can be found in this context focuses on young people who offend, or on older children. With the age of criminal responsibility in Scotland (age 8) being one of the lowest in developed countries, the legal context and categorization for much of the existing literature is not strictly applicable to the Scottish client group. In addition, the variation between studies—differences in terminology, assessment types, rationale for studies and also small sample sizes in many cases—makes it difficult to generalize findings. There are, however, a number of factors that appear consistently in the literature that are also borne out by the current findings, such as the majority of clients being male (e.g. Taylor, 2003), family disruption, disadvantage and high incidence of abuse and/or neglect (e.g. Burton, 2000), and a high proportion having some kind of learning disability (e.g. Dolan et al., 1996).

There are, however, some notable differences in the findings from the current study to those reported in previous literature worthy of further exploration. For example, a little under half of clients were living with their parent(s) at time of referral, much lower than has been reported in previous studies (e.g. 73% in Manocha & Mezey, 1998). In addition, almost one-third of clients in the current study were reported as having both male and female victims, while this figure is reported in single digits in other studies (e.g. 7% in Dolan et al., 1996; 6% in Manocha & Mezey, 1998).

It is hoped that the continuing work with the Champions Group, and use of the client monitoring form, will contribute to addressing some of the questions raised by this preliminary analysis and discussion, and in turn go some way towards contributing to the development of services and interventions for children with harmful sexual behaviours.

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Comparing the developmental and behavioural characteristics of female and male juveniles who present with sexually abusive behaviour

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Abstract *Relatively few studies have compared female and male juveniles who sexually abuse. These studies have reported that while female juveniles with sexually abusive behaviour are more likely to have experienced childhood sexual abuse, they display similar patterns of abusive behaviour. However, to date these findings have not been replicated in a UK sample. The current study compared 22 female and 254 male juveniles, referred to a UK specialist community forensic service, in relation to family environment, maltreatment experience, psychiatric diagnoses and perpetrated abusive behaviour. Consistent with previous studies perpetrated behaviour was similar across genders, but females were significantly more likely to have been sexually victimized as children, at a younger age and by a greater number of abusers. In addition, they were more likely to have been exposed to inadequate sexual boundaries at home. These findings suggest that females and males may follow different pathways to sexually abusive behaviour.*

Keywords *Childhood sexual abuse; developmental; female; juvenile; sexually abusive behaviour*

Introduction

It is relatively recently that western societies have acknowledged that children and adolescents are capable of perpetrating sexually abusive behaviour (SAB) (Hickey, Vizard, French & McCrory, 2006; Veneziano & Veneziano, 2002). Juveniles who display such behaviour have been the subject of considerably less empirical investigation than adults who sexually abuse. However, even among studies of juveniles most research has focused upon males. Cultural attitudes towards female sexuality do not sit easily with the phenomenon of female perpetrated sexual aggression, whether in juveniles or adults (Hetherington, 1999). Nevertheless,

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official estimates suggest that female juveniles account for approximately 9% of arrests for sexual offences and 2% of forcible rapes (Snyder, 2005).

The dearth of research on female juveniles may be due in part to the fact that relatively few such individuals come to the attention of assessment and treatment services. This contributes to a major methodological limitation when investigating gender effects: namely, small sample sizes. Consequently, as Schmidt and Pierce (2004) have stated, only tentative aetiological and clinical conclusions can be drawn at this time about the similarities and differences between the genders.

Comparisons between female and male juveniles who sexually abuse

Fehrenbach and Monastersky's (1988) review of female juveniles who sexually abuse comprised 28 juveniles aged 10–18 years recruited from a university-based treatment programme. The only developmental factors reported in the study concerned victimization experiences. At least 50% of the sample were victims of sexual abuse, 21% were victims of physical abuse, whereas only two members of the sample were victims of both.

In relation to the perpetrated SAB, Fehrenbach and Monastersky (1988) reported that all the offences were committed without accomplices, which is an important difference from adult female abusers. More than half the sample (53.6%) was referred because they had perpetrated penetrative behaviour (vaginal, anal or oral) against their victims using fingers or objects. The remaining females were referred for offences involving sexual touching that did not include penetration. In addition, only one member of the sample had abused an adult, whereas all the others had abused victims under 12 years of age. Only two of the sample had abused both male and female victims while 57% had abused *only* females and 36% had abused *only* male victims. All the victims were known previously to the perpetrators as either relatives or acquaintances.

The females were not compared concurrently to a sample of male juveniles; however, Fehrenbach and Monastersky (1988) made broad comparisons with a sample of male juveniles who sexually abused on whom they had previously published data (Fehrenbach, Smith, Monastersky & Deisher, 1986). They concluded that the females tended to be younger than the males, were more likely to have been the victims of sexual abuse and were more likely to victimize children rather than peers.

The sample reported by Johnson (1989) is unique, as it comprised 13 female children (aged 4–12 years) rather than adolescents. Again, it did not include a control sample of male children. Nonetheless, the study includes a comprehensive description of the developmental and sexually abusive behaviour characteristics of the sample. For instance, only one child lived with both biological parents, 85% of the mothers were victims of sexual abuse and 54% were assessed as having drug or alcohol abuse problems. All the girls were reported to be “academically and socially deficient” and some engaged in additional antisocial behaviours such as fire-setting and stealing. All the girls were victims of sexual abuse, with 11 (85%) of them having been abused by their relatives, while 31% had been physically abused.

With regard to the perpetrated SAB, eight of the 13 girls penetrated (vaginally or anally) their victim with either fingers or objects, although all the girls had some form of physical contact with their victim. All the victims were under 11 years of age. In contrast to Fehrenbach and Monastersky's (1988) findings, half of Johnson's (1989) sample abused both male and female victims. Johnson (1998) also reported a 2:1 ratio for male and female victims. However, as with Fehrenbach and Monastersky (1989), Johnson (1988) found that in her sample all the victims were known to the perpetrators.

Findings by Mathews, Hunter and Vuz (1997) came from the largest comparison study, involving 67 female juveniles who sexually abuse (aged 11–18 years) and 70 male juveniles who sexually abuse (aged 11–17 years). However, because the data for the two samples was collected using different methodologies and at different times, between-group statistical comparisons were not conducted.

A greater proportion of females (77.6%) than males (44.3%) were victims of sexual abuse. Similarly, 60% of the females were victims of physical abuse compared to only 44.9% of the males. The females had a greater mean number of sexual abusers (4.5) compared to the males (1.4); were abused at an earlier age (64% before the age of 5 years) compared to the males (26% before 5 years of age); and were more likely to have been abused by both men and women (38%) compared to males (7%). Mathews et al. (1997) also reported that half the females in their sample met the clinical criteria for a diagnosis of post-traumatic stress disorder (PTSD).

With regard to the characteristics of the SAB, similar proportions of females (78%) and males (75%) were reported to have “fondled” their victims, although only 27% of the females compared to 55% of the males had penetrated (vaginally or anally) their victims. The genders were equally likely to abuse both male and female victims (31% of females and 21% of males), and to abuse children under 11 years of age (87% of females and 94% of males). Finally, only a small proportion of both genders abused strangers (8% of females and 3% of males).

Additional studies (Bumby, Halstenson & Bumby, 1997; Hendriks & Bijleveld, 2006; Kubik, Hecker & Righthand, 2002; Ray & English, 1995; Vandiver & Teske, 2006) also compared samples of females and males. Their findings are largely consistent with the studies presented above. In particular, the females were more likely to have been exposed to childhood sexual abuse (CSA) than the males, while few group differences were observed in relation to the characteristics of their SAB.

In summary, consistencies in relation to developmental characteristics are apparent across previous studies. First, female juveniles who sexually abuse are more likely than males to have been victims of childhood sexual abuse (Robinson, 2005). Secondly, the sexual abuse suffered by the females appears to be more severe in that they typically have greater numbers of abusers, are abused by a broader variety of abusers and are abused from an earlier age (Mathews et al., 1997).

In relation to the SAB perpetrated by females and males a generally consistent picture emerges across studies. Both genders tend to target known male and female children rather than adults, and perpetrate contact sexual abusive behaviours. When only one gender is targeted females are more likely than males to abuse boys.

The current study

Although previous studies have compared female and male juveniles who sexually abuse, both Fehrenbach and Monastersky (1988) and Mathews et al. (1997) were not able to test statistically for group differences. Furthermore, with the exception of Mathews et al. (1997) and Vandiver and Teske (2006), the female samples were small. All the studies reviewed above were based on non-UK samples; consequently, the reported gender differences have not been validated in a UK sample. Finally, a history of childhood sexual abuse is associated consistently with females rather than males who sexually abuse, suggesting that it is important to consider the factors that may mediate the relationship between CSA and SAB. Among adult female perpetrators of SAB Christopher, Lutz-Zois and Reinhardt (2007) hypothesized that “severe disruption in social functioning and affect regulation” resulting in personality disorder traits may mediate the relationship. Although

they did not find statistical support for the hypothesis, they found that the CSA experienced by the sexual abusers was more severe than the CSA experienced by a comparison group of female non-sexual offenders.

The current study aimed to (i) contribute to the literature by validating the previously identified gender differences in a comparative sample of UK female and male juveniles who sexually abuse; (ii) explore other factors (response to trauma and CSA characteristics) that may be relevant to the relationship between CSA and SAB; and (iii) identify the characteristics that predict gender group membership. On the basis of previous research it was hypothesized that females would be characterized by higher rates of childhood sexual abuse and more severe forms of such abuse. In contrast, it was expected that the pattern of perpetrated SAB would be comparable across genders, with the possible exception of rates of penetration. Aims (ii) and (iii) were exploratory in nature.

Method

Participants

All participants were referred to a community-based, specialist juvenile forensic service between 1992 and 2003 as a result of perpetrating sexually abusive behaviour (Vizard, Hickey, French & McCrory, 2007). Only those who committed at least one act of SAB against a victim (as opposed to only exhibiting non-contact sexually inappropriate behaviour or worrying sexual thoughts) were included in the analysis. This resulted in a cohort of 22 females and 254 males. Previous studies have been limited by small female sample sizes and the current study is similarly limited. In addition, the size of the comparison group of male juveniles is much larger than the females. Therefore, statistical analyses were conducted on an exploratory basis only. To guard against Types I and II errors the distribution of continuous variables were tested for normality and, where appropriate, non-parametric tests were applied. Similarly, when testing statistical significance pertaining to categorical variables it was ensured that expected cell assumptions were not violated; in instances where this did occur, Fisher's exact significance level is cited. Finally, effect sizes were calculated in order to provide an alternative measure of group differences.

Both genders were predominantly white (91% and 82% of females and males, respectively) and of a similar age at the time of the service's original assessment; females were an average age of 13.4 years [standard deviation (s.d.) 2.6] and males an average age of 14.1 years (s.d. 2.6). A higher proportion of females (40.9%) than males (23.2%) had an IQ of less than 70, as assessed using the Wechsler Intelligence Scale for Children—third edition (WISC-III), although the difference did not reach statistical significance ($\chi^2_{(1)} = 3.40$, $p = 0.065$).

Data collection

Data was collected by the first author (NH), using a standardized pro-forma, from case files that contained reports from a variety of professionals and agencies including psychiatrists, psychologists and social workers. Therefore, multiple sources were used to rate the items. Although the number of reports per file varied, at a minimum each case had undergone an external social services' family assessment. As a consequence of the variability it was necessary to rate items as "don't know" if there was no reference to the item being absent in the case. However, given that the sample comprised seriously conduct-disordered young people, there

was confidence that if an item had been of concern it would have been referenced within the reports. Nonetheless, because many of the variables were coded either “yes” or “don’t know” it is acknowledged that the results are likely to underestimate the true prevalence of some variables. However, this is unlikely to affect the outcome of the between-group comparisons because the limitation applies to all cases.

Although the external reports in the case files were gathered at the time of the clinical assessment they were written originally at various times during the life of the young person. Consequently, they provide contemporaneous accounts of the life of the young person. An independent rater scored 8% of the case files to assess inter-rater reliability. A mean Cohen’s kappa of $\kappa = 0.60$ was obtained, which can be regarded as “substantial” (Landis & Koch, 1977). Therefore, only ratings by the first rater were used in subsequent analyses.

The following parent and family factors were coded (present/absent).

- *Parental history of abuse* (parents suffered sexual, physical or emotional abuse as children).
- *Parental separation/divorce* (separation or divorce between biological parents).
- *Inconsistent parenting* (child received different messages about their behaviour from different parents, or divergent messages from the same parent).
- *Lack of parental supervision* (parents repeatedly unaware of where children were or who they were with).
- *Inadequate family sexual boundaries* (child exposed to sexually inappropriate material and/or adult sexual activity within the family).
- *Intergenerational sexual abuse* (suspected or actual sexual abuse between different generations of the family but not involving the young person).
- *Convicted sex offender in the family* (a family member had been convicted of sexual offences against a child but not involving the young person).

The following abuse factors were coded (present/absent).

- *Childhood sexual abuse (CSA)* (actual or suspected sexual assault).
- *Physical abuse* (actual or suspected physical injury).
- *Emotional abuse* (actual or suspected rejection, emotional neglect or abandonment).
- *Physical neglect* (actual or suspected persistent neglect of a child’s physical needs for food, warmth, or medical attention).
- *Exposure to family violence* (actual, or suspected, witnessing/exposure to violence between adult family members).

Response to trauma was operationalized as diagnoses of PTSD and reactive attachment disorder (RAD). The diagnoses were made according to Diagnostic and Statistical Manual version IV (DSM-IV) criteria by a child psychiatrist as part of the service’s clinical assessment.

The SAB characteristics analysed in this study were based on the combined episodes of sexually abusive behaviour perpetrated by each juvenile rather than just the most recent act. This was performed to provide a more accurate “profile” of the SAB. The characteristics comprised: age at onset of SAB, gender of victim(s); relationship between perpetrator and victim(s); age difference between perpetrator and victim(s); and acts perpetrated.

Statistical analysis

First, group differences in relation to parent, family, maltreatment, psychiatric diagnosis and SAB characteristics were assessed. Group comparisons involving categorical variables were

analysed using χ^2 tests; Mann–Whitney U-tests were used for comparisons involving continuous variables as they were found not to be distributed normally. Logistic regression was used to assess the independent predictors of gender. We also report the effect size for each statistical test. All analyses were conducted using SPSS version 14.

Results

Parental, family and maltreatment characteristics and psychiatric diagnoses

The results presented in Table I indicate that, as predicted, females were significantly more likely than males to have experienced childhood sexual abuse ($\chi^2_{(1)}=6.78$, $p=0.009$). The results also show that females were significantly more likely to have been brought up in families characterized by inadequate family sexual boundaries ($\chi^2_{(1)}=10.60$, $p=0.001$). According to the odds ratio, females were 4.8 times more likely than males to have been exposed to adult sexual activity or inappropriate sexual material within their families.

While females had families with higher rates of intergenerational sexual abuse, higher rates of parents with abuse histories and higher rates of emotional abuse, these differences did not reach statistical significance. With regard to psychiatric diagnoses females were significantly more likely than males to have reached the threshold for diagnoses of PTSD and RAD.

Table I. Parent, family, maltreatment and psychiatric diagnoses characteristics.

	Females (n = 22)		Males (n = 254)		Effect size OR (95% CI)
	%	n	%	n	
Parental and family factors					
Parental history of abuse	59.1%	(13)	38.2%	(97)	
Parental separation/divorce	77.3%	(17)	72.8%	(185)	
Inconsistent parenting	81.8%	(18)	62.2%	(158)	
Lack of parental supervision	68.2%	(15)	46.9%	(119)	
Inadequate sexual boundaries in the family	77.3%	(17)	41.3%	(105)**	4.8 (1.7–13.5)
Intergenerational sexual abuse	22.7%	(5)	15.0%	(38)	
Schedule 1 offender in family	31.8%	(7)	27.2%	(69)	
Abuse					
Childhood sexual abuse	95.5%	(21)	69.9%	(176)**	9.3 (1.2–70.4)
Physical abuse	63.6%	(14)	66.9%	(170)	
Emotional abuse	90.9%	(20)	72.0%	(183)	
Physical neglect	77.3%	(17)	57.5%	(146)	
Exposure to family violence	36.4%	(8)	49.2%	(125)	
Psychiatric diagnoses					
DSM PTSD diagnosis	59.1%	(13)	26.4%	(67)**	4.0 (1.6–9.9)
DSM RAD diagnosis	40.9%	(9)	15.4%	(39)**	3.8 (1.5–9.5)
				(Fisher's exact)	

** $p \leq 0.01$; *** $p \leq 0.001$. DSM: Diagnostic and Statistical Manual; PTSD: post-traumatic stress disorder; RAD: reactive attachment disorder; CI: confidence interval; OR: odds ratio.

Characteristics of childhood sexual abuse victimization

Comparisons between the females and males who had been victims of childhood sexual abuse (see Table II) supported our predictions that the females would experience more severe forms of abuse. For instance, the females were abused by significantly greater numbers of abusers ($U = 1073.00$, $p = 0.000$, $r = 0.30$) and were more likely to have been abused by a variety of abusers, including family and friends of both genders. Additionally, the females were significantly younger than the males when their childhood sexual victimization began ($U = 560.00$, $p = 0.000$, $r = 0.22$).

Perpetrated sexually abusive behaviour characteristics

Males were more likely to penetrate their victims (see Table III), with 61% of the males penetrating their victims compared to only 31.2% of the females ($\chi^2_{(1)} = 7.12$, $p = 0.008$). We also found that the females, with a median age of 6 years, were significantly younger than the males (median age 10 years) at the onset of the SAB ($U = 1397.00$, $p = 0.005$, $r = 0.17$).

The only significant difference between genders in terms of the victims they abused indicates that the odds of abusing a victim at least five years younger than the perpetrator was 3.5 times higher for the males than the females ($\chi^2_{(1)} = 7.77$, $p = 0.005$). In fact, in our sample 17.8% of the males had only ever abused victims aged more than five years younger than themselves, while none of the females had targeted exclusively such young victims.

Characteristics predictive of the gender of juveniles who sexually abuse

The individual, CSA and SAB factors on which the genders differed significantly were analysed using logistic regression to determine which, if any, could predict the gender of the juveniles in this sample. None of the inter-item correlations exceeded 0.64, therefore there was no evidence for multicollinearity. All the factors were then entered into a forced entry regression model. The Hosmer–Lemeshow statistic ($\chi^2_{(3)} = 1.295$, $p = 0.730$) indicated that the model was a good fit for the data, and according to the Nagelkerke R^2 statistic accounted for 25% of the variance in gender. Only one factor achieved significance (the total number of

Table II. *Childhood sexual abuse characteristics.*

	Females (n = 21)		Males (n = 176)		Effect size r
Median age at which CSA first experienced ^a	4 years (2.5–5 years)		7 years (4–10 years)***		0.22
Median number of CSA abusers	3.5 (2–5)		1 (0–2)***		0.30
	%	n	%	n	OR (95%CI)
Abused by relatives	85.7%	(18)	57.4%	(101)*	4.5 (1.3–15.7)
Abused by relatives and acquaintances	57.1%	(12)	28.4%	(50)**	3.4 (1.3–8.5)
Abused by females	57.1%	(12)	36.9%	(65)	
Abused by males	95.2%	(20)	87.5%	(154)	
Abused by females and males	57.1%	(12)	30.1%	(53)*	3.1 (1.2–1.8)
Any penetration	76.2%	(16)	58.0%	(102)	
Verbal coercion	38.1%	(8)	29.5%	(52)	

^aDenominator for females = 17, males = 146. Figures denote medians and quartiles in parentheses. Significance levels are based on the Mann–Whitney U-tests for the age of onset and number of abusers and χ^2 tests for all other variables. * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$. CI: confidence interval; CSA: childhood sexual abuse; OR: odds ratio.

Table III. Sexually abusive behaviour characteristics.

	Females (n=22)		Males (n=254)		Effect size
Median age at onset of SAB ^a	6 years (4–10.1)		10 years (7–12.7)**		0.17
Victims	%	n	%	n	
Abused any male victims	59.1%	(13)	57.5%	(146)	
Abused any female victims	86.4%	(19)	89.4%	(227)	
Abused male and female victims	50.0%	(11)	47.6%	(121)	
Abused relatives	45.5%	(10)	65.0%	(165)	
Abused friends or acquaintances	81.8%	(18)	71.7%	(182)	
Abused strangers	9.1%	(2)	11.0%	(28)	
Abused any victims >5 years younger than abuser	31.8%	(7)	62.2%	(158)**	3.5 (1.4–8.9)
Only abused victims >5 years younger than abuser	0%	0	17.8%	(44)	
Abuse perpetrated					
Any penetration (vaginal or anal)	31.8%	(7)	61.0%	(155)**	3.4 (1.3–8.5)
Any sexual/genital fondling	77.3%	(17)	85.0%	(216)	
Any oral–genital contact with victim	40.9%	(9)	32.7%	(83)	
Any verbal coercion/threats	27.3%	(6)	37.8%	(96)	
Any physical coercion/threats	9.1%	(2)	7.5%	(19)	

^aDenominator for females = 19, males = 239. Figures denote medians and quartiles in parentheses. Significance levels are based on Mann–Whitney U-tests for the age of onset and χ^2 tests for all other variables. * $p < 0.05$; ** $p < 0.01$. SAB: sexually abusive behaviour.

CSA abusers) [$\beta = 0.729$, standard error (s.e.) = 0.143, ExpB = 2.07, 95% confidence interval (CI) 1.6–2.7, $p = 0.000$], indicating that being a female, rather than male, juvenile who sexually abuses is predicted by having a higher number of CSA abusers.

Discussion

The main findings from previous comparative studies were replicated in this UK sample of juveniles. We found that while females and males share many developmental characteristics they differ significantly in their previous experience of childhood sexual abuse. Nearly every female in our sample was a victim of childhood sexual abuse, which accords with the proportions reported by Bumby et al. (1997), Johnson (1989), Mathews et al. (1997) and Ray and English (1995). The proportion of males who were sexually abused in our sample (69.9%) is, however, somewhat higher than the proportion reported by Mathews et al. (1997) (44%). Our finding that females have higher rates of sexual victimization than males is also consistent with findings from studies of non-sexually abusing female juvenile delinquents (Lader, Singleton & Meltzer, 2003).

The proportion of females in our study who were sexually abused by their own relatives (85%) was similar to the proportion reported by Johnson (1989), and our finding that females were younger at the onset of CSA than males was reported similarly by Mathews et al. (1997). The 59% prevalence rate of PTSD diagnoses among the females is comparable to Mathews et al.'s (1997) rate of 50% and indicates the presence of a high level of traumatic symptoms in the female sample. This result complements Vick, McRoy and Mathews' (2002) and Cauffman, Feldman, Waterman and Steiner's (1998) findings among non-sexually abusing female and male delinquents.

With regard to the CSA, the females were more likely to be sexually victimized by a greater variety of abusers (by relatives and acquaintances, and by both males and females). In addition they were significantly more likely to come from families characterized by inadequate sexual boundaries. This more severe pattern of early sexual maltreatment may have contributed to the increased levels of PTSD and RAD in the female sample, although we cannot comment on cause and effect in the current study.

In relation to the SAB characteristics, the findings are consistent with a comparable behavioural profile across genders. In accord with Mathews et al.'s (1997) findings, males were more likely to penetrate their victims and were more likely to specialize in abusing much younger victims. The finding that females were less likely than males to sexually abuse victims of the opposite sex is consistent with both Fehrenbach and Monastersky (1988) and Vandiver and Teske (2006). The prevalence rate among the females in this sample for abusing strangers (9%) is higher than reported by Fehrenbach and Monastersky (1988) and Johnson (1989), but is consistent with the proportion (8%) cited by Mathews et al. (1997). The novel finding reported here was the fact that females were significantly younger than the males when they first exhibited sexually abusive behaviour.

Gender-related aetiological differences

Our findings support those from previous studies suggesting that female juveniles who sexually abuse may have a different developmental trajectory to males who sexually abuse; one in which a history of childhood sexual abuse is of greater consequence. Nonetheless, it is possible that these findings are spurious and merely an artefact of gender biases. Specifically, professionals may be more inclined to look for evidence of CSA among females than males thus inflating the prevalence rates. If this is the case, then such biases apparently occur in all countries and settings in which the research takes place. Nevertheless, while it may account for some differences, the proportion of males identified as CSA victims in the current sample (69%) suggests that many professionals do consider CSA in male histories. Furthermore, it can be argued that because of the theoretical link between exposure to CSA and SAB that exists in this field, many professionals' inclination to assess CSA is increased irrespective of gender. Such an inclination may not exist for professionals in the wider juvenile delinquency field, where the link between CSA and perpetrating delinquency is less salient.

We also found that females were significantly more likely than males to come from families that exhibited inadequate sexual boundaries. This suggests further that early, inappropriate sexualization is particularly pertinent to understanding the development of SAB in females, especially when this is linked to our finding that they have a significantly earlier onset of sexually abusive behaviour. Hunter, Lexier, Goodwin, Browne and Dennis (1993) also suggested that being abused by a female may be an additional risk factor for the development of SAB among females via modelling or the "eroticization" of female aggression. Although the females in our sample had a higher rate of CSA by women compared to males, this finding did not reach statistical significance.

However, a history of sexual victimization cannot be sufficient to explain the development of sexually abusive behaviour in females (Garland & Dougher, 1990). Females are generally more likely than males to be victims of CSA, with an estimated 21% of girls having been sexually victimized before the age of 18 (Cawson, Wattam, Brooker & Kelly, 2000). Therefore, if childhood sexual abuse was sufficient to explain the development of SAB in females the prevalence of such victimization should result in far greater numbers of female juvenile perpetrators than actually observed. Christopher et al. (2007) hypothesized that the

mechanism underpinning the relationship between CSA and SAB in adult female abusers concerned their response to the traumatic sexualization, which manifested in antisocial and borderline personality traits such as disrupted social functioning and affect regulation. Our finding, that particular features of the CSA and the environment in which the abuse took place were associated significantly with females, suggests that they may be implicated in the relationship between CSA and SAB among juvenile females. Furthermore, one of the CSA characteristics (total number of abusers) was the best predictor of gender in this sample, accounting for 25% of the variance.

Until recently the dearth of research comparing female and male juveniles who sexually abuse mirrored the meagre research comparing female and male non-sexually abusing delinquents. However, emerging research in the latter field suggests that although female and male juvenile delinquents share many aetiological risk factors (Fergusson & Horwood, 2002; Moffitt, Caspi, Rutter & Silva, 2001), gender differences in relation to victimization experiences are reported routinely (Daigle, Cullen & Wright, 2007; Widom, 1989). Irrespective of the type of offence committed, female delinquents report higher rates of childhood sexual abuse than males (Lader et al., 2003), and female juvenile delinquents have also been shown to have higher rates of sexual abuse than non-offending female juveniles (Dixon, Howie & Starling, 2004). Therefore, it is possible that the sexual victimization-related gender differences observed among juveniles who sexually abuse reflects a broader distinction between male and female juvenile delinquents.

Our findings also suggest that although the SAB rarely differs between males and females, the pathways to perpetrating the behaviour may differ. Moreover, the pathways vary most crucially on early sexualization experiences with such experiences appearing to have greater salience among females. The mechanisms explaining how and why these experiences are more important in the female pathway to SAB are not understood fully. The results from the current study suggest that part of the explanation could lie in the nature of the childhood sexual victimization and the psychological response to traumatic sexualization. Further research is required to explore additional explanations, including intimacy deficits and sexual arousal as motivating factors in the SAB perpetrated by female juveniles.

The current study is characterized by a number of methodological limitations that prompt a level of caution when interpreting the findings presented. First, the sample of females is relatively small, in contrast to the relatively large sample of males. Small samples of females are the norm in previous research, and while it is desirable from a statistical position to have larger samples, these are unusual in routine clinical settings. The disparity in the gender sample sizes was taken into consideration and parametric and non-parametric statistical tests were used accordingly. Furthermore, effect sizes were reported to enable group differences to be evaluated adequately.

Secondly, it is possible that there was a bias in the type of females referred. It may be that only females viewed as “high risk” were referred by external professionals. As such, the results may not be readily generalizable to all female juvenile perpetrators.

Thirdly, the study’s reliance on file data, albeit drawn from multiple sources, limited the ability to include additional information about the young person’s clinical presentation which ought to be considered in gender comparisons. Finally, the absence of a control sample of non-sexually abusing female delinquents precluded conclusions about the generic influence of victimization differences between female and male juveniles.

Conclusions

The current study validates previous research findings in a UK sample and offers tentative support for the view that although male and female juveniles commit very similar patterns of SAB, their pathways to the behaviour appear to differ with respect to their experiences of childhood sexual abuse. Specifically, females presenting with SAB are not only more likely to be sexually victimized, and at an earlier age, they tend to be victimized by a more diverse and greater number of abusers. In addition, they are more likely to experience environments with poorer sexual boundaries. This general pattern is consistent with the higher levels of CSA reported for non-sexually abusing female juvenile delinquents (Lader et al., 2003). The females also started to perpetrate SAB at a younger age than the males. The small sample size in the current study means that future research with larger groups will be required to replicate and extend these findings. Control samples of non-sexually abusing delinquents will also be needed to explore the mechanisms by which exposure to early and severe sexual victimization appears to increase the risk of perpetrating sexually abusive behaviour among female juveniles.

Assuming that the statistical differences observed in the current study reflect genuine gender differences, a number of clinical implications can be drawn. There is an emerging case for identifying females at risk of developing sexually abusive behaviour; those who have experienced early, severe CSA from more than one abuser. The presence of SAB in girls should alert clinicians to the importance of assessing childhood experiences comprehensively, given the greater likelihood of severe CSA in this group. In addition, we would argue that the treatment of the psychological effects of severe CSA among females who have committed SAB should be a priority (Blues, Moffat & Telford, 1999).

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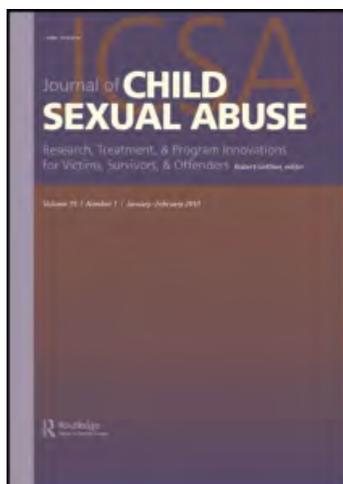
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Differences Between Sexually Abused and Non-Sexually Abused Adolescent Girls in Foster Care

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Differences Between Sexually Abused and Non-Sexually Abused Adolescent Girls in Foster Care

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ABSTRACT. This descriptive study examines the differences between sexually abused and non-sexually abused adolescent females in the foster care system who were participating in an independent living program. Fifty-four percent of the 190 girls met the criteria for being categorized as sexually abused. Those who experienced sexual abuse had also experienced significantly more of other types of child maltreatment. In addition, those who had been sexually abused were much more likely to be living in a congregate living setting, such as a group home or residential

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center, than those who were not sexually abused. The girls who had been sexually abused exhibited significantly more behavioral difficulties, including internalizing and externalizing problems, with 51% of them having clinically significant scores on the Youth Self-Report version of the Child Behavior Checklist. When co-occurrence of substance use and mental health problems were examined, sexually abused girls were significantly more likely than the non-sexually abused girls to meet the established criteria. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2002 by The Haworth Press, Inc. All rights reserved.]

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It has been well established that the short and long term consequences of child maltreatment can have devastating and long lasting emotional and psychological effects (for a review, see Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992). Based on information from the National Child Abuse and Neglect Data System (NCANDS) approximately 879,000 children were abused or neglected in 2000. The vast majority of children (63%) were neglected, 19% physically abused, 10% sexually abused, and close to 8% emotionally or psychologically abused (U.S. Department of Health and Human Services, 2002). In an effort to end the maltreatment of a child and reduce the potential for ongoing harm, placement in foster care is sometimes necessary. In 2000, nearly one fifth of those identified victims of child maltreatment (21%) were removed from their homes and placed in foster care (U.S. Department of Health and Human Services, 2002). Unfortunately the report by the U.S. Department of Health and Human Services did not provide information about the type of maltreatment that led to those children being placed in foster care.

One study, however, provided information about the type of maltreatment leading to children being placed in foster care. Garland, Landsverk, Hough and Ellis-MacLeod (1996) found that the majority (54%) of children were placed due to neglect or caretaker absence. About one fifth of the children were placed in foster care as a result of being physically abused, 11% for being sexually abused and 8% for a

combination of sexual, physical and emotional abuse. Six percent of the children had been removed for protective reasons, meaning there was not necessarily evidence that they had been abused, but reason to think they were at risk (e.g., being the sibling of an abused child).

It has been estimated that there are more than 500,000 children in foster care in this country as a result of some form of child maltreatment (Maza, 1996). Unfortunately, there is growing evidence that many foster care youth remain in care for an extended period of time who, upon leaving to live on their own, experience a variety of functional difficulties that seriously compromise their future (e.g., Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 1998). Among the difficulties that are most often cited in the literature on foster care youth are problems related to mental health, substance use and education.

NATIONAL DATA ON MENTAL HEALTH AND SUBSTANCE USE

The 2001 National Household Survey on Drug Abuse (NHSDA), which is conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides the most current information available on the illicit use of alcohol and drugs by noninstitutionalized civilians aged 12 and older in the United States (SAMHSA, 2002). In addition to the information it provides on substance and alcohol use, it includes information on mental health treatment. Among youth between the ages of 12 and 17, 4.3 million (18.4%) received mental health treatment within the previous 12 months. Nearly 8% of those youth were hospitalized for their treatment. The primary reasons cited for treatment were for feeling depressed (45%), acting out (22%) and thinking about suicide (17%). Girls were somewhat more likely than boys to receive mental health treatment (20% vs. 17%), and their rates of treatment increased with age, while that of boys declined (age 16-17; 22% vs. 14%). In addition, those youth that reported using illicit drugs in the previous 12 months had higher rates of mental health treatment than those who did not use drugs (26% vs. 16%). Nearly 11% of youths between the ages of 12 and 17 reported being users of illicit drugs, with boys revealing slightly higher rates of use than girls (11% vs. 10%). Seventeen percent of those youth had consumed alcohol in the previous month, with 10% being identified as binge drinkers and 2.5% as heavy drinkers. Rates of alcohol use were virtually identical between males and females (17.2% vs. 17.3%), but males had higher rates of bingeing and drinking heavily (SAMHSA).

MENTAL HEALTH AMONG FOSTER CARE YOUTH

Youth in foster care appear to have a much greater need for mental health services than the youth surveyed in the SAMHSA (2002) study. Although definitions of mental health vary, a number of studies provide evidence of the prevalence of mental health problems among foster care youth. Hulseley and White (1989), using the Achenbach Child Behavior Checklist, determined that children in out-of-home-care had significantly more problematic behavior than a control group. In the Iglehart (1994) study, 22% of the foster care youth were found to have mental health problems, while Cook and colleagues (1991) concluded that 38% of their sample was mentally disturbed. In a study conducted by Trupin and associates (1993), 72% of the youth in foster care exhibited emotional disturbances sufficiently severe as to be indistinguishable from a criterion group of youth in intensive mental health treatment programs. Mech, Ludy-Dobson, and Hulseman (1994) reported that over half of the foster care youth in their study had social-emotional adjustment problems. One study found that 60 to 80% of their sample had psychiatric problems (Thompson & Fuhr, 1992). In 1995, Pilowski reviewed studies that had been published between 1974 through 1994 and concluded that among foster care youth, externalizing disorders were more prevalent than internalizing disorders.

Mental health problems have been shown to be significant barriers in the development of independent living skills needed to successfully transition out of care (Iglehart, 1994). Youth, who have had higher rates of placement disruptions, in conjunction with emotional and behavioral problems, appear to be the least prepared for independent living (Cooper, Peterson, & Meier, 1987, as cited in Iglehart, 1994; Iglehart, 1994; Proch & Taber, 1985, as cited in Iglehart). Length of time in care as well as placement location, both of which can affect one's mental health, also have been found to have an effect on a youth's ability to be ready for and experience positive outcomes upon exiting care (Iglehart, 1994; Courtney & Barth, 1996).

SUBSTANCE USE AMONG FOSTER CARE YOUTH

Although data on the prevalence of substance abuse among foster care youth are limited, it has been identified as a factor that can substantially negatively impact successful self-sufficiency upon exiting from the foster care system (Barth, 1990; Cook, McLean, & Ansell, 1991). In

an early study, Jones and Moses (1984) found that 20% of the foster care youth in their study had alcohol problems. Barth (1990) found that 19% of his sample reported drinking at least once per week and 56% had used illegal drugs while in care; 20% had used in the past month. Of those who had used drugs, half of them had done so at least once a week during their last month in care. Fifty-six percent of the sample reported using drugs after becoming too old to remain in care (Barth, 1990). The study conducted by Cook and colleagues (1991) found that 17% of the youth exiting care were identified as having drug abuse problems and 12% had alcohol problems. Overall, in comparison to the youths in the 2001 National Household Survey on Drug Abuse, these studies seem to indicate that youth in foster care are using alcohol and drugs with more frequency than the average adolescent in the country.

EDUCATION

In an effort to provide the best estimate of high school completion rates among foster care youth, Mech (1994) reanalyzed data from four previous studies (Barth, 1990; Cook, McLean & Ansell, 1991; Festinger, 1983; Jones & Moses, 1984) and found that 58% of foster care youth completed high school. In a recent study by Blome (1997), which was conducted with a nationally representative sample, a number of important distinctions regarding education were found between foster care and non-foster care youth. The foster care youth studied less, were less likely to take college preparatory classes and dropped out with greater frequency (37% versus 16%). They were also more likely to have been disciplined in school and to have changed schools with more frequency. Despite these differences, however, foster care and non-foster care youth did not differ significantly in terms of educational aspirations.

THE CURRENT STUDY

Reviewing the literature provides a compelling picture of the many difficulties that foster care youth experience. This literature, however, does not differentiate the ways in which these problems may be explained by differing forms of child maltreatment. In fact, the broader literature on child maltreatment fails to address such differences, preferring to compare maltreated and non-maltreated populations, which could result in a loss of critical information needed to strengthen intervention

strategies (Garland, Landsverk, Hough, & Macleod, 1996). This study will examine such differences by comparing sexually abused and non-sexually abused girls in foster care through a sample of 190 females involved in the foster care system in one Midwest suburban county. While a number of factors will be examined, education, mental health, and substance abuse will be emphasized given their demonstrated importance on future outcomes for foster care youth.

METHOD

Participants

Participants were youths age 15 through 19 in foster care or out-of-home placements through the Division of Family Services (DFS) of St. Louis County, Missouri. Referrals to the study were made by social workers from DFS, group home workers, foster or biological parents, and the youths themselves.

The original study sample consisted of 351 foster care youth aged 15 to 19 years ($M = 16.33$, $SD = .85$), more than half of whom (54%; $n = 190$) were female. It is the female portion of the sample that is the focus of the current study. The average age of the girls in the sample was 16 ($SD = .86$) and 54% ($n = 102$) of them indicated having experienced some form of sexual abuse in their lifetime. Fifty-eight percent of the girls identified their racial background as Black, 33% as White, and 9% as Other. Ninety-two of the girls reported living with a biological parent at some point in their lives. However, at the time of the pretest interviews, 51% of the girls lived in a congregate living setting (group home or residential center), while the remaining 49% lived in a family or foster care home situation. Seventeen percent of the girls reported that they had at some point lived on the street. At the time they were interviewed, twelve of the girls had children and two were pregnant.

Procedures

Data for this study were collected during a baseline assessment of a larger study to evaluate an 8-month HIV prevention and life skills program. The purpose of the program was to assist youths in attaining life skills to prepare them for discharge from state custody. Trained graduate students pursuing a master's degree in social work conducted structured interviews, which lasted approximately one hour. The structured

interviews consisted of several standardized instruments and questionnaires designed to capture data on the variables of interest described in detail in the measurement section.

Masters-level students in social work were trained to conduct the structured interviews. The training was delivered over the course of 20 hours. Interviewers were given an overview of the study and trained in the informed consent and confidentiality procedures. Each standardized instrument and questionnaire included in the interview was reviewed in detail. Students were taught general interviewing skills, and also underwent sensitivity training. Full-length interview role-plays were required of all students before they were able to begin conducting the structured interviews with study subjects.

Prospective participants for the present study were excluded if they displayed any of the following characteristics: (1) severe learning problems; (2) severe behavioral problems such as violent behavior not under control; or (3) severe emotional problems whose symptoms would prohibit their participation in a group situation. Eligibility was assessed by social workers through a brief screening interview. Before each youth was screened, consent was obtained from their legal guardian.

The screening criteria were established to exclude foster care youth with problems so severe that they would be incapable of meaningfully participating in the project (e.g., severe learning problems to the extent of being unable to read or write). The intention was to include as many youth as possible, recognizing that it was highly likely that the youth would have many problems. In actuality, no youth were excluded based on severe learning problems or emotional problems, despite the fact that some of the youth had to be hospitalized in a mental health facility while participating in the project. Only four youth were excluded from the project for severe behavioral problems because they were seen as being incapable of participating without seriously disrupting the group process.

Measures

Demographics and Background Living Situations. Demographic, background living situation, and other descriptive characteristics of the youths were measured via a structured questionnaire that was adapted from previous research on HIV prevention with youths in group homes (Slonim-Nevo, Auslander, & Ozawa, 1995; Slonim-Nevo, Auslander, Ozawa, & Jung, 1996). Demographic variables assessed included: age, race, gender, primary caretaker, current legal guardian, number of foster or group home placements, number of years living in out-of-home

care, type of current living situation (i.e., group home or foster home), and educational levels of important adults in the youths' lives.

Education. Descriptive educational information was obtained through items in a structured questionnaire developed by Slonim-Nevo, Auslander, and Ozawa (1995) for an earlier HIV prevention study for youths in residential treatment centers. The items provided data such as year in school, youths' plans in terms of educational goals (i.e., vocational or technical school, job-training program, junior college, or part or full-time four-year college), level of confidence in their ability to actually achieve their educational goal, number of different schools attended due to placement changes, number of suspensions/expulsions and reasons for same, whether the youth was held back a grade, frequency of skipping school, and fighting with teachers (coded as either yes or no). In addition, frequency of fighting was also obtained (Slonim-Nevo, Auslander, & Ozawa, 1995). For the variable "school instability," two items were utilized: number of school districts and number of mid-year school changes.

Sexual Abuse and Childhood Trauma Questionnaire. Two measures were utilized to assess childhood trauma. Child sexual abuse was assessed with three questions about unwanted sexual experiences that were adapted from those used by Russell (1986) and several subsequent researchers. The questions were modified to be more age-appropriate and potentially less confusing to youth. Consequently, words such as intercourse, genitals and rectal were replaced with words such as sex, private parts and anal sex. In Russell's original questions, she also put age parameters around the questions (e.g., before turning 14), which did not seem relevant for the foster care youth. Consequently, the adapted questions that were used with the foster care youth were as follows: (1) "Did anyone get you to touch their private parts against your wishes?" (2) "Did anyone touch your private parts against your wishes?" and (3) "Has anyone ever had vaginal sex, anal sex, or oral sex with you against your wishes?" If a youth answered in the affirmative to any one of the three questions, she was categorized as having been sexually abused.

The Childhood Trauma Questionnaire (Bernstein & Fink, 1998) was used to assess other kinds of childhood maltreatment. Four subscales measured the following constructs, utilizing five items per scale: (1) Emotional Abuse ($r = 0.85$), (2) Physical Abuse ($r = 0.86$), (3) Emotional Neglect ($r = 0.87$), and (4) Physical Neglect ($r = 0.82$). Response choices are on a five-point Likert-type scale: never true, rarely true, sometimes true, often true, and very often true. Higher scores reflect a greater severity of abuse.

Mental Health and Behavioral Problems. The Youth Self-Report (YSR) version of the Child Behavior Checklist (CBCL) (Achenbach, 1991) was used to assess the behavioral problems and competencies of the participants. The YSR includes the following problem scales: (1) Withdrawn, (2) Somatic Complaints, (3) Anxious/Depressed, (4) Unpopular/Social Problems, (5) Thought Disorder, (6) Attention Problems, (7) Delinquent Behavior, (8) Aggressive Behavior, (9) Self Destructive Behavior, (10) Internalizing, and (11) Externalizing (Achenbach, 1991). For this study, 94 of the original 103 items were utilized; items measuring socially desirable characteristics and social competence were removed in order to shorten the instrument. Previous research showed that criterion validity has been established by the ability of the YSR to discriminate between referred and non-referred children (partialling for demographic effects) on the basis of quantitative scales (Achenbach, 1991). For the present study, internal consistency reliability (Cronbach's alphas) was as follows: Internalizing subscale ($r = 0.90$), Externalizing subscale ($r = 0.85$), and Total Behavior Problems ($r = 0.94$).

Alcohol and Other Drug Use. Portions of the alcohol and drug use sections of the Diagnostic Interview Schedule for Children-Revised Version (DISC-R) initially developed by Costello and colleagues was used to measure substance use, abuse and dependence (Costello, Edelbrock, Dulcan, Kalas, & Klaric, 1984). The scale measuring alcohol dependence and abuse consists of 21 items and the scale measuring substance use and abuse consists of 18 items. The DISC-R assesses a wide range of symptom information in language suitable for use with children ages 6-18. For this study, six items were used to assess frequency and problems related to alcohol use (e.g., "In the past six months, have you drunk any beer, wine, wine coolers, hard liquor, or any other alcoholic drinks?" "On how many occasions have you drunk . . . in the past six months?", etc.). Other drug use, such as marijuana use, was measured by inquiring about use in the past six months. Frequency of drug use during the past six months was assessed by providing six possible responses: 40+, 20 to 39, 10 to 19, 6 to 9, 3 to 5, and 1 to 2 times. Youths were also asked if they had been in trouble while using drugs, with responses being coded as yes = 1 or no = 0. Inter-rater reliability and validity have been reported to be high in previous research (Shaffer et al., 1996; Shaffer et al., 1993).

Future Orientation. Future orientation was measured by combining six items derived from the Life Orientation Test (Scheier, Carver, & Bridges, 1994) and six items derived from the Future Time Perspective Inventory (Gjesme, 1979). Items measured youths' expectations for

things to go their way, concern about the present, and feelings of uncertainty about the future. Sample items from the Life Orientation Test included, "I usually expect the best" and "If something will go wrong for me it will." Sample items from the Future Time Perspective included, "The future seems very unclear and uncertain to me" and "I am most concerned about how I feel now in the present." For each item, youths responded using a 4-point Likert-type scale from "Strongly Agree" to "Strongly Disagree." The total scale reflects the summed scores for the 12 items. The scale had a normal distribution with an internal consistency of $r = 0.70$. Three subscales were also developed: a 3-item "Optimistic" subscale ($r = 0.65$), a 4-item "In the present" subscale ($r = 0.53$), and a "Negative View" 3-item subscale ($r = 0.41$).

RESULTS

Demographic and Background Characteristics

Chi-squares and t-tests were run to determine differences in demographic and background characteristics between the sexually abused and non-sexually abused adolescent girls. With regard to demographics, there were more similarities than differences between the groups. There were no significant differences between the groups in terms of age, ethnicity, education level, or religious attendance.

Educational Plans

Approximately 76% of the sample of adolescent girls was in school at the time that their interviews were conducted. On average, they were in the tenth grade ($SD = .96$). They indicated that they had changed schools or school districts 1.5 times since the seventh grade. There was a significant difference between the sexually abused and non-sexually abused girls in school ($\chi^2(1) = 4.66, p = .031$), such that 84% of the non-sexually abused girls reported being in school, while only 71% of the sexually abused girls did so.

Most of those in high school were planning to finish (77%), while nearly everyone else (22%) was planning to get a GED. Here again, a significant difference was found between the two groups as 89% of the non-sexually abused girls, versus 66% of the sexually abused girls, were planning to finish high school ($\chi^2(2) = 13.1, p = .001$). In addition,

of those planning to get a GED ($n = 38$), the largest percentage (76%) were those who had been sexually abused ($\chi^2(2) = 13.1, p = .001$).

Overall, the girls felt relatively confident in their plans, with 85% of the non-sexually abused, and 73% of the sexually abused, indicating they were very sure of their plans. Furthermore, 96% of the sample had educational plans for after high school without any meaningful differences emerging between the groups. Nearly 10% of the sample intended to obtain vocational or job training, 10% to join the military, 27% to attend a two-year college, 28% to attend a four-year college, and 22% to go beyond college. The confidence levels for these educational plans were not as strong, however, as those expressed with regard to completing high school. Nonetheless, 73% of the non-sexually abused girls and 51% of the sexually abused girls felt very sure of their educational plans, with only 2.8% of the girls (all of whom were sexually abused; $n = 5$) indicating that they were not very sure of their plans ($\chi^2(2) = 11.04, p = .004$).

Future Orientation

The groups appeared to be nearly identical in terms of future orientation. Both the sexually abused and the non-sexually abused girls had a mean of 2.2 on the full future orientation scale, 2.7 on the “In the Present” subscale, and 2.5 on the “Negative View” subscale. On the “Optimism” subscale, a non-significant minor difference between groups was found with the sexually abused girls having a slightly higher mean score ($M = 1.9; SD = .55$) than the non-sexually abused girls ($M = 1.8; SD = .54$). These findings indicate that there were no meaningful differences in future orientation between sexually abused and non-sexually abused girls in this sample of adolescents in foster care.

Current Living Situation

Girls who had been sexually abused were much more likely to be living in a congregate living setting such as a group home or residential center (64% vs. 35%), whereas the non-sexually abused girls were more likely to be in a family or foster care home situation ($\chi^2(2) = 17.1, p < .001$). Additionally, while sexually abused girls reported having been in an average of four different group homes, the non-sexually abused girls had been in an average of two ($t(181) = -4.64, p < .001$). In terms of foster families, the sexually abused girls were slightly higher in their av-

erage number of placements (2.12 versus 1.4) than the non-sexually abused girls ($t(182) = -1.9, p = .059$), although the difference was not statistically significant. The non-sexually abused girls reported having been in their current placement for an average of 18.6 months, compared to the sexually abused girls who had been at their residence 13.7 months, which appears to indicate more stability in length of time in placement. However, this difference was not found to be significant ($t(187) = 1.37, p = .18$).

Childhood Abuse History

As indicated previously, 54% ($n = 102$) of the girls met the criteria for being categorized as sexually abused, a percentage comparable to that found among children in out-of-home care reported by Hargrave (1991). Ninety-one percent of those who had been sexually abused ($n = 92$) reported that they had experienced unwanted touching of their genitals, 71% ($n = 72$) had been forced to have sex, and 70% ($n = 71$) had been forced to touch someone else's genitals.

On each of the Childhood Trauma questionnaire subscales, the sexually abused girls had significantly higher scores, indicating more abuse experience than the non-sexually abused girls. The differences were significant for each of the subscales. These differences are reported in Table 1.

Mental Health and Behavioral Problems

A striking difference found was that 37% of the girls who had been sexually abused had been in a mental health facility in the previous year as compared to only 18% of the non-sexually abused girls ($\chi^2(1) = 5.18, p = .02$). Similar rates were found when looking at whether they had ever been in a mental health facility with 41% of the sexually abused and 21% of the non-sexually abused answering in the affirmative ($\chi^2(1) = 8.9, p = .003$).

In addition, a significantly higher percentage (74%) of the sexually abused girls were taking some form of prescription medication as compared to the non-sexually abused girls (47%) ($\chi^2(1) = 13.8, p < .001$). Given the large number of girls who had previously been in a mental health facility, it seemed relevant to determine the percentage of the girls taking medication for mental health conditions. Forty-five percent of the sexually abused girls and 24% of the non-sexually abused girls were taking some type of psychotropic medication, a difference that approached, but did not reach, significance ($\chi^2(1) = 8.7, p = .003$).

TABLE 1. Mean Scores and Standard Deviations of Trauma Type by Group

Variables	Group	Mean Score (SD)	<i>n</i>	<i>p</i> values
Physical Neglect	Sexually Abused	11.3 (5.5)	101	.003
	Non-Sexually Abused	9.1 (4.6)	87	
Physical Abuse	Sexually Abused	14.0 (6.5)	100	< .001
	Non-Sexually Abused	10.4 (5.1)	87	
Emotional Neglect	Sexually Abused	14.8 (5.6)	102	< .001
	Non-Sexually Abused	11.9 (5.4)	87	
Emotional Abuse	Sexually Abused	15.6 (5.9)	102	< .001
	Non-Sexually Abused	10.8 (5.3)	87	
Non-Sexual Trauma Total Score	Sexually Abused	55.5 (20.4)	100	< .001
	Non-Sexually Abused	42.2 (16.4)	87	

Notes: Childhood Trauma Questionnaire Subscales. Ranges for each subscale are as follows: Physical Neglect, 5-25; Physical Abuse, 5-25; Emotional Neglect, 5-25; Emotional Abuse, 5-25. Non-Sexual Trauma Total Score, 20-100.

As indicated previously, the Youth Self-Report (Achenbach, 1991) was used to assess the behavioral problems and competencies of youths in the study. Significant between group differences were found for every subscale. The sexually abused girls had consistently higher scores on every indicator, reflecting more behavioral problems, both in terms of internalizing and externalizing behaviors, than the non-sexually abused girls. These differences are shown in Table 2.

Combining the scores from each of the subscales (with the exception of the internalizing and externalizing subscales), a total Youth Self-Report score was derived. Not surprisingly, the between group comparison revealed that the sexually abused girls were experiencing significantly more behavioral problems overall than the non-sexually abused girls ($t(180) = -4.28, p < .001$) (see Table 2). Furthermore, on the Youth Self-Report the borderline cut-point ($T \geq 60$) is used to differentiate clinically significant from nonclinically significant scores. Fifty-one percent of the sexually abused girls had clinically significant

TABLE 2. Mean Scores and Standard Deviations on Behavioral Problems by Group

Variable	Group	Mean (SD)	<i>n</i>	<i>p</i> values
Withdrawn	Sexually Abused	5.6 (2.8)	102	.001
	Non-Sexually Abused	4.2 (2.8)	87	
Somatic Complaints	Sexually Abused	5.0 (3.4)	102	.002
	Non-Sexually Abused	3.6 (3.0)	87	
Anxious Depressed	Sexually Abused	9.8 (6.3)	101	< .001
	Non-Sexually Abused	5.8 (4.6)	87	
Social Problems	Sexually Abused	3.7 (2.7)	102	.001
	Non-Sexually Abused	2.5 (2.3)	87	
Thought Problems	Sexually Abused	4.4 (3.0)	102	.009
	Non-Sexually Abused	3.4 (2.4)	86	
Attention Problems	Sexually Abused	7.0 (3.5)	101	.001
	Non-Sexually Abused	5.2 (3.5)	86	
Delinquent Behavior	Sexually Abused	5.3 (3.1)	102	.018
	Non-Sexually Abused	4.3 (2.7)	86	
Aggressive Behavior	Sexually Abused	10.8 (6.0)	101	.005
	Non-Sexually Abused	8.4 (5.6)	86	
Self Destructive	Sexually Abused	4.0 (3.6)	101	< .001
	Non-Sexually Abused	2.0 (2.4)	87	
Internalizing ^a	Sexually Abused	19.4 (10.0)	101	< .001
	Non-Sexually Abused	13.1 (8.5)	87	
Externalizing ^b	Sexually Abused	16.2 (8.1)	101	.003
	Non-Sexually Abused	12.7 (7.4)	86	
Total	Sexually Abused	59.4 (25.2)	99	< .001
	Non-Sexually Abused	44.2 (21.9)	83	

^a The Internalizing subscale is a summation of the Withdrawn, Anxious/Depressed, and Somatic Complaints subscales.

^b The Externalizing subscale is a summation of the Delinquent and Aggressive subscales.

scores, compared to 27% of the non-sexually abused girls, a difference that was statistically significant ($\chi^2(2) = 10.9, p = .004$).

It should be noted that the bivariate analyses of these behavioral problems were conducted using 12 separate t-tests, which creates a risk for committing a Type 1 error given an alpha level of .05. A more conservative approach to interpreting the data involves using Bonferroni's correction to set the alpha level at .0042. Even with such a conservative

approach, all but three of the behavioral problems (thought, delinquent and aggressive) remained significantly different between the groups, consistently revealing more behavioral problems for the sexually abused girls than the non-sexually abused girls.

Delinquent Behavior

Runaway behavior was relatively frequent for both groups without a significant difference between the two ($t(186) = -1.84, p = .07$), despite the fact that the sexually abused girls ran away nearly twice as often ($M = 4.95; SD = 11.9$) as the non-sexually abused girls ($M = 2.4; SD = 4.9$). In terms of having ever been in detention or jail, 41% of the sexually abused girls and 24% of the non-sexually abused girls had the experience at some point in their lives (33% of sample), a difference that was significant ($\chi^2(1) = 6.1, p = .013$). In fact, the sexually abused girls had been in detention or jail an average of 3.3 times ($SD = 3.8$), which was only slightly more often as the non-sexually abused girls ($M = 2.4; SD = 1.3$), a difference that was not significant ($t(61) = -1.8, p = .08$).

Sexual Behavior

A significantly higher percentage of sexually abused girls (82%) had sexual intercourse than non-sexually abused girls (70%) ($\chi^2(1) = 4.12, p = .042$). In addition, the sexually abused girls had had significantly more sexual partners ($M = 4.8$) than the non-sexually abused girls ($M = 2.9$) ($t(138) = -2.13, p = .035$). However, in terms of age at the time of first having non-coercive sexual intercourse, although the sexually abused girls were slightly younger ($M = 13.9$) than the non-sexually abused girls ($M = 14.5$), the difference found was not significant ($t(141) = 1.9, p = .056$).

Thirty-one percent of the sexually abused girls versus 12.6% of the non-sexually abused girls indicated that they had oral sex at some point, a difference that was significant ($\chi^2(1) = 9.0, p = .003$). When asked about having had sex under the influence of drugs and/or alcohol, 57% of the sexually abused girls, versus 28% of the non-sexually abused girls, answered in the affirmative. This difference was significant ($\chi^2(1) = 11.7, p = .001$). A small number of girls ($n = 11$) acknowledged having traded sex for food, drugs or money, and nine of those girls were sexual abuse survivors ($\chi^2(1) = 2.7, p = .10$). A similarly small number of girls acknowledged having had anal sex ($n = 14$) and

again, the vast majority (86%) were sexual abuse survivors ($\chi^2(1) = 6.2, p = .013$).

Alcohol and Substance Use

In general, there did not appear to be much difference between sexually and non-sexually abused girls in terms of alcohol and drug use. In assessing use of alcohol or marijuana over the preceding six months, no significant differences were found. Over half of the girls indicated that they had not used either alcohol or drugs in the preceding six months. Of the girls who did report using alcohol or drugs, 13% used alcohol only, 10% used marijuana only and 27% used both. Within this later category, 33% of the sexually abused girls, versus 18% of the non-sexually abused girls, indicated using both in the previous 6 months. As stated above, this difference was not statistically significant. It should be noted that numerous questions were asked about other types of drugs, but those items were so seldom endorsed as to make analysis of them impossible.

Co-Occurrence of Substance Use and Mental Health Problems

A chi-square test was run to look at between group differences on four categories that were developed to examine issues of co-occurrence: substance use problems only, mental health problems only, both substance use and mental health problems, and neither substance use nor mental health problems. The results indicated that the between group differences were significant ($\chi^2(3) = 12.29, p = .006$). Perhaps most striking was the fact that 46% of the non-sexually abused girls fell into the category of having neither a history of substance use nor mental health problems, compared to 25% of the sexually abused girls. In contrast, 29% of the sexually abused girls versus 16% of the non-sexually abused girls had both substance use and mental health problems. The girls that had been sexually abused were almost twice as likely as those who had not been sexually abused to have only mental health problems (21% versus 11%). As indicated in the previous section, no meaningful differences were noted in terms of substance use. However, a slightly higher percentage of the non-sexually abused girls (28%) than the sexually abused girls (24%) fell in the substance use only category.

Multivariate Analysis

Based on the bivariate relationships found in the initial analyses, multivariate analyses were run in the form of direct logistic regression to determine which variables could predict group membership (sexually abused or non-sexually abused). Logistic regression is recommended when one is interested in predicting group membership from a mix of discrete, continuous, or dichotomous variables (Tabachnic & Fidell, 2001), which is the case in this study. Using the SPSS logistic procedure, the analysis was performed with sexual abuse status as the outcome and three predictor variables: Total Non-Sexual Childhood Trauma score, Total Youth Self Report score on behavior problems, and current living situation.

The Total Non-Sexual Childhood Trauma score was based on a summation of scores of the four subscales (emotional abuse, physical abuse, emotional neglect, and physical neglect) used from the Childhood Trauma Questionnaire. Likewise, the Total Youth Self Report score was based on combining the scores of several problem subscales (withdrawn, somatic complaints, anxious/depressed, unpopular/social problems, thought disorder, attention problems, delinquent behavior, aggressive behavior, self-destructive behavior). Current living situation was a dichotomous variable categorized as either congregate living (group home or residential facility) or a family/foster family home situation. Nine cases with missing values were deleted, leaving 181 female adolescents available for the analysis: 98 sexually abused adolescents and 83 non-sexually abused adolescents.

The full model was tested with all three predictor variables against the constant-only model and was found to be statistically significant ($\chi^2 = 30.73, p < .0001$) indicating that the predictors were able to distinguish between sexually abused and non-sexually abused adolescent females in foster care. Given that the dependent variable is dichotomous, there is no traditional R^2 indicating the amount of variance explained; however, a pseudo-measure of explained variance can be computed for the model using the log-likelihood estimates (Nagelkerke, 1991). Therefore, an estimate of the strength of the model was calculated using Nagelkerke- $R^2 = .21$.

Table 3 provides a summary of the most relevant statistics for the odds ratios for each of the three predictors. The Wald chi-square statistic was used to test the statistical significance of the odds ratio, and both the Total Non-Sexual Childhood Trauma score ($\chi^2 = 9.6, p = .002$) and

TABLE 3. Logistic Regression Analysis of Sexual Abuse Status

Predictor Variables	β	Wald Test	Odds Ratio	95% Confidence Interval for Odds Ratio	
				Lower	Upper
Non-Sexual Trauma Total Scale Score	.028	9.59	1.03	1.01	1.05
Behavioral Problems Total Scale Score	.021	7.42	1.02	1.01	1.04
Current Living Situation	.145	1.61	1.16	.924	1.45

Youth Self Report on behavior problems ($\chi^2 = 7.4, p = .006$) effectively predicted sexual abuse status. Current living situation did not reach the established significance level needed to be effective as a predictor ($\chi^2 = 1.6, p = .20$). The Wald test also provides a way to evaluate the contribution of each of the predictor variables to the model. Total Non-Sexual Childhood Trauma appeared to make the biggest contribution as a predictor in the model ($\chi^2 = 9.6$), followed by Youth Self-Report of problem behaviors ($\chi^2 = 7.4$) and current living situation ($\chi^2 = 1.6$).

For every one-unit increase in score on the Total Non-Sexual Childhood Trauma measure, there is a 3% increase in the predicted odds of being in the sexually abused group. For every one-unit increase in score on the total Youth Self-Report scale, there is a 2% increase in the predicted odds of being in the sexually abused group.

DISCUSSION

The findings from this study reveal that there are both similarities as well as important differences between sexually abused and non-sexually abused adolescent girls in foster care. For the most part, the girls did not differ significantly in terms of their delinquent behavior, alcohol and substance use, educational plans or future orientation. Perhaps surprisingly, a substantial percentage of both groups of girls were refraining from using alcohol or substances, were in school and planning to finish, and were relatively confident about their post-high school educational plans. The groups were virtually identical in terms of future orientation, with both expressing moderately positive views about their futures.

One of the patterns that emerged from the data is that girls who had experienced some form of sexual abuse had also experienced signifi-

cantly more emotional and physical neglect and abuse, compared to the girls who had not reported any sexual abuse experiences. The presence of multiple forms of childhood trauma makes it difficult to discern the unique impact that the sexual trauma contributes to their functional difficulties. However, a recent study by Bagley and Mallick (2000) indicated that after controlling for the effects of emotional and physical abuse, sexual abuse continued to be significantly associated with emotional problems.

Nevertheless, it should be noted that some of the effects typically attributed to sexual abuse might be more associated with a pathogenic home environment (Harter, Alexander, & Neimeyer, 1988; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993; Wyatt & Newcomb, 1990). Given that this study involves a sample of adolescent girls in foster care it seems reasonable to assume that each of the youths has come from a pathogenic home environment. Furthermore, one would expect that each of the youths would be suffering from some degree of psychological difficulty as a result of the trauma and family disruptions experienced. So, to what extent does the experience of sexual abuse seem to differentiate these girls in foster care?

When type of maltreatment was taken into consideration, the sexually abused girls showed a consistent pattern of marked increase in clinically significant symptomology compared to the youth that had not experienced sexual abuse. The most significant differences were seen around mental health and behavioral problems. The sexually abused girls had higher scores (more behavioral problems) on every subscale of the Total Youth Self-Report. Even with a conservative interpretation of the data, the sexually abused girls were more likely than the non-sexually abused girls to be withdrawn, have somatic complaints, be anxious and depressed, have social and attention problems, engage in self destructive behaviors, and to externalize as well as internalize their distress.

The sexually abused girls were also more likely to have been hospitalized and to be taking psychotropic medications. Although the data do not provide any information about the reasons for hospitalization, suicide ideation is a possible explanation; it is a symptom often exhibited by survivors of childhood sexual abuse (Briere & Runtz, 1986; Bryer, Nelson, Miller, & Krol, 1987). Alternatively, it is possible that the differences in hospitalization and medication were enhanced by a propensity within the foster care system to emphasize mental health treatment for children who have been identified as sexual abuse survivors (Garland, Landsverk, Hough, & Ellis-MacLeod, 1996).

Although a higher percentage of sexually abused girls than non-sexually abused girls were found to be experiencing serious mental health and behavioral problems, it is clear that across types of maltreatment a large percentage of the girls in this sample are in psychological distress. One would hope that needed mental health services would be made available in foster care. Garland and her colleagues (1996) found that 56% of the youth in foster care in their sample had, within the first six months of being in care, received mental health services. Interestingly, service utilization was driven by type of maltreatment experienced rather than by actual psychological need. Those youth identified as having been sexually abused were found to be 4.5 times more likely to receive services than the non-sexually abused youth, regardless of level of need.

Thus, the type of maltreatment experienced may determine the mental health treatment made available rather than the degree of symptomology. This means that many of the non-sexually abused girls in the current study who are in need of mental health services may be at risk for not receiving them. And, while the sexually abused girls are more likely to receive services if their abuse is known, given their clinically significant level of problems identified, one could argue that what they have received has not been sufficient to meet their needs.

Within the HIV prevention study, from which the current study was drawn, the type of maltreatment experienced, leading to placement in foster care, was not recorded. As a result, the system-identified type of maltreatment experienced by the youth was not available for analysis in the current study. Consequently, it is quite possible that a number of the sexually abused girls were placed because of physical abuse or neglect, and are not known within the system as having been sexually abused. It is also possible that subsequent to placement some form of sexual abuse occurred that was never disclosed. As indicated above, this could seriously affect their access to mental health services.

Given the documented correlation between childhood sexual abuse and substance abuse, it was remarkable to see that there were no significant differences on this issue between the groups. In fact, given the prevalence of substance use among adolescents in the general population, it was surprising to see that over 50% of the girls in this sample indicated they had not used alcohol or marijuana in the previous six months. While it is possible that the respondents underreported their alcohol and drug use, research suggests that self-reports are relatively reliable indicators of use (Maisto, Connors, & Allen, 1995). Perhaps there was a lack of significance because adolescence is a time in life where

experimentation with alcohol and drugs occurs aside from precipitating life events. Another possible explanation is that while one would expect to see significant differences in alcohol and drug use within the general population, a troubled population, such as foster care youth, may not have as much of a range in consumption patterns. It is also possible that the environments in which foster care youth reside play some role in their not using. Nonetheless, it is significant that 27% of the sample reported using alcohol and/or drugs within the previous 6 months.

The analysis of co-occurrence of substance use and mental health problems revealed that there were significant differences between sexually abused and non-sexually abused adolescent girls. It seems clinically significant that 29% of the sexual abuse survivors and 16% of the non-sexual abuse survivors (23% of the sample) met the criteria for co-occurrence. Although formal diagnoses of substance abuse disorders and mental health disorders were not conducted in this study, other studies have shown that in the presence of a substance abuse disorder it is very common to find at least one co-existing disorder (Burkstein, Brent & Kaminer, 1989; Clark & Neighbors, 1996). Among girls with a substance abuse disorder there is a tendency to find comorbidity with internalizing types of disorders such as PTSD and depression (Clark et al., 1997). Given the internalizing symptomology of the sexually abused girls in the sample, those who are using substances would appear to be at an increased risk for the development of such a comorbid condition. Furthermore, the comorbidity of substance abuse and depression has been found to be common among adolescents who have completed suicide (Carlson & Grayson, 1991). In addition, an association with suicide attempts has been found for adolescents who have experienced physical and/or sexual abuse (Deykin & McNamera, 1985; Stone, 1993). Thus, the girls that met criteria for co-occurrence in our study would appear to be at an increased risk for attempting suicide.

It was disturbing to see the significantly elevated frequency of placing sexually abused girls in congregate living situations. Adolescents in congregate living environments have been found to have lower readiness assessment levels for independent living than do adolescents in foster home placements (Mech, Ludy-Dobson, & Hulseman, 1994). Moreover, previous studies have indicated that youth that have been living in family types of placements have more support and are better prepared for independent living. Nevertheless, sexually abused girls seem to have a particular disadvantage in the foster care system, in that they are harder to place in family environments. Certainly the emotional in-

stability and numerous behavioral problems exhibited by sexually abused girls present serious challenges.

Youth who are in need of more intensive and structured care are more likely to be placed in congregate living settings (Barth & Berry, 1989). As this study illustrates, sexually abused girls appear to experience a greater number of mental health and behavioral problems than non-sexually abused girls, which might make it necessary to place them in group homes or other residential environments. Certainly, the fact that so many of the sexually abused girls had been in a mental health facility speaks to the degree of psychological distress and instability experienced by them. Consequently, their mental health and behavioral problems may make them harder to place. Foster families may be reluctant to take adolescent youths with such challenging backgrounds and problems. They may feel that they do not possess the skills needed to adequately meet the needs of these adolescents. Their reluctance might be intensified by fears of the possibility of sexually abused girls lodging false allegations of sexual abuse against them, a concern that is garnering increasing amounts of attention in the literature (Swan, 1997).

More needs to be done to increase the opportunities for family type placements for sexually abused girls. Swan (1997) suggests the idea of using and supporting alternatives to the traditional form of family (heterosexual mother and father conforming to socially expected gender roles). For example, one non-traditional family form that she recommends includes shared parenting. Swan challenges the notion of gender-based care-taking models to encourage the equal involvement of foster fathers in the parenting process. She also recommends placing sexually abused girls with lesbian couples or single women as additional models of non-traditional families. In addition, she advocates for more extensive and specialized training so that foster families can be better prepared for addressing the needs of these girls and less frightened by fears of false allegations. This is a serious issue that requires attention. To continue to relegate the sexually abused to congregate living maintains a system of care that places them at increased risk for negative outcomes upon exiting care.

LIMITATIONS

The data used in this study were collected during a baseline assessment of a larger study designed to evaluate an 8-month HIV prevention and life skills program. As a result, a number of variables that might

have been useful in more fully exploring the similarities and differences between sexually abused and non-sexually abused adolescent females in foster care were not gathered. For example, the severity of the impact of childhood sexual abuse has been found to be associated with a number of abuse-specific variables: age at onset, relationship to the offender, frequency and duration, type of sexual acts involved, and use of force (Beitchman et al., 1991; Beitchman et al., 1992). However, such information about the nature of the sexual abuse was not solicited given the purpose of the HIV prevention study.

Likewise, there are limitations to the definition of sexual abuse. Three questions were asked that capture various aspects of unwanted sexual contact, which given the age of the respondents, can be classified as sexual abuse. However, there was no way to discern whether the sexual abuse occurred inside or outside of the home, or whether it was perpetrated by a parent, sibling, relative, acquaintance, dating partner or stranger. Thus, it is unclear whether we were looking at incest, non-familial sexual abuse, or dating violence, which has potential implications for the severity of the effects, as well as the findings.

Moreover, some researchers have found that to increase the likelihood of disclosure of sexual abuse, multiple questions need to be asked in different ways (Bolen & Scannapieco, 1999; Williams, Siegel, & Jackson, 2000). It is possible that the three questions asked were not sufficient to facilitate full disclosure from the sample. Shame, stigma, denial, and dissociation can all contribute to a sexual abuse survivor not disclosing their sexual abuse history. Thus, some of the girls in this study who were categorized as non-sexually abused, might actually be sexual abuse survivors who did not disclose. If that is the case, it may account for some of the lack of significant differences between the two groups.

In addition, the girls in this study may not be representative of all the girls in foster care. Participation in an independent living program is an option available to foster care youth, but not all youth are equally aware of that option or choose to participate. As such, there may be significant differences between those who know about and choose to participate and those that are not aware or decline the offer to participate. In addition, some foster care youth are not eligible to participate if they have severe learning, behavior or emotional problems. It is possible that without the eligibility requirements more distinct differences between the sexually abused and non-sexually abused girls might have emerged. Finally, the data used in this study are cross-sectional, only capturing information from one point in time. Perhaps longitudinal data would re-

veal different trends in terms of between group differences on measures of substance use, mental health and behavioral problems.

CONCLUSION

Not surprisingly, the results of this study provide much about which to be concerned clinically. The constellation of problems identified places these youth at high risk for negative independent living outcomes, such as unemployment, poverty, mental illness, addiction, homelessness, incarceration, revictimization and suicide. Every effort must be made to provide the mental health services needed by these youths, both for the remainder of their time in care and after exiting. Furthermore, additional research is needed to examine the unique ways in which type of maltreatment experienced affects the psychosocial needs of youth in foster care. As research and practice help clarify these distinctions, perhaps more effective abuse-specific interventions can be developed, implemented and evaluated.

It is important, however, to also acknowledge that a sizable number of these girls, both the sexually abused and non-sexually abused, were functioning well and were optimistic about their future. Twenty-five percent of the sexually abused girls had neither a history of substance use nor mental health problems. Practitioners cannot assume that an adolescent who has experienced maltreatment and been in foster care is by default someone with mental health or behavioral problems. Care must be taken to ensure that these girls who have survived great difficulties are not stereotyped and pathologized. While childhood sexual abuse is a very traumatic experience, there is an emerging literature documenting the incredible resiliency of survivors (Lam & Grossman, 1997; Valentine & Feinauer, 1993). More research is needed in this area, particularly with a population of adolescent girls in foster care.

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FAMILY VIOLENCE AND JUVENILE SEX OFFENDING

The Potential Mediating Role of Psychopathic Traits and Negative Attitudes Toward Women

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Juvenile sex offenders were compared to other juvenile offenders in the degree of violence against women they witnessed in their families of origin. Poor impulse control, a callous and unemotional interpersonal style, and sexist attitudes toward women were tested as potential mediators of this relation. Participants were 70 incarcerated juvenile males, ages 13 to 18, from three offender categories: 23 sex offenders, 17 violent offenders, and 30 noncontact offenders. Results indicated that the witnessing of severe domestic violence was related not only to juvenile sex offending but to contact offending in general. There were no group differences on measures of poor impulse control or sexist attitudes toward women. However, sex offenders were found to have more callous and unemotional traits than other offenders. Therefore, although these traits do not mediate the effects of witnessing family violence, they do seem to be important in distinguishing juvenile sex offenders from other juvenile offenders.

AUTHORS' NOTE: *Results of this study were presented at the 1996 (November) annual convention of the Association for Advancement of Behavior Therapy, New York. Correspondence concerning this article should be addressed to Paul J. Frick, Department of Psychology, University of New Orleans, 2001 Geology and Psychology Bldg., New Orleans, LA 70148; e-mail: pfrick@uno.edu.*

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Juvenile sex offenses pose a serious problem for society. Yet until recently, they have been largely ignored in the research literature. One possible reason for this neglect is the belief that these offenses are uncommon (Becker, 1988). However, adolescent sex offenses constitute a sizable proportion of all committed sex offenses. For instance, juveniles have been reported to be the offenders in more than one fourth of all child sexual abuse cases (Groth, Longo, & McFadin, 1982). According to the Uniform Crime Report (UCR) of the Federal Bureau of Investigation (FBI), adolescents committed 20% of the forcible rapes reported to the FBI in 1981 (Davis & Leitenberg, 1987). The 1985 UCR revealed 50 arrests per 100,000 adolescent boys for forcible rape (L. L. Oliver, Nagayama Hall, & Neuhaus, 1993). A more recent report indicated that 15,300 cases involving violent sexual offenses by juveniles were handled in 1992 by juvenile courts (Butts et al., 1995).

Another possible reason for the limited research focus on adolescent sex offenders is the assumption that these acts are exploratory in nature and hence will not continue into adulthood. This assumption is not supported by research. Close to one half of all adult sex offenders report committing their first sexual offense in their teenage years (Groth et al., 1982) and there appears to be significant continuity in the patterns of sexual offending in adolescence and adulthood with respect to the age of the victims, the amount of coercion, and other circumstances surrounding the sexual assault (Groth, 1977; Porter, 1990).

Due to these misconceptions and resulting lack of research, the understanding of factors that lead to sex offending, relative to other types of juvenile offending, is somewhat limited. Consistent with research on juvenile offending in general (e.g., Loeber & Stouthamer-Loeber, 1986), the available research has focused on family variables that could play a role in the behavior of the adolescent sex offender. Such variables include family configuration (Fagan & Wexler, 1988; Pierce & Pierce, 1987), family criminality (Awad & Saunders, 1991; Fagan & Wexler, 1988; L. L. Oliver et al., 1993; Pierce & Pierce, 1987; Smith, 1988), and the rates of physical and sexual abuse suffered by adolescent sex offenders themselves (Awad & Saunders, 1989; Becker, Cunningham-Rathner, & Kaplan, 1987; Fagan & Wexler, 1988; Fehrenbach, Smith, Monastersky, & Deisher, 1986;

Haapasalo & Hamalainen, 1996; Knight & Prentky, 1993; Pierce & Pierce, 1987; Porter, 1990; Smith, 1988; Spaccarelli, Bowden, Coatsworth, & Kim, 1997).

One critical aspect of the adolescent sexual offender's family environment that has been investigated is the high rate of physical violence between parents witnessed by the adolescent (Haapasalo & Hamalainen, 1996; Lewis, Shanok, & Pincus, 1981; Mio, Nanjundappa, Verleur, & Dobkin de Rios, 1986; Smith, 1988; Spaccarelli et al., 1997). Parental conflict in general has also been associated with bullying behavior in school (R. Oliver, Oaks, & Hoover, 1994) and an increased likelihood for children to make hostile attributions (Fraser, 1996), both of which could be associated with sexual offending. Lewis et al. (1981) directly tested the link between family violence and sex offending and reported that 79% of the juvenile sex offenders in their sample had observed violence within the family, as opposed to 20% of the nonviolent delinquent comparison group. Also, the severity of the sex offenses committed by adolescents has been found to vary as a function of degree of violence directed toward the offenders' mothers (Smith, 1988).

Two important issues remain inadequately addressed in this literature linking family violence to juvenile sex offenders. First, although sex offenders clearly witness greater rates of domestic violence than nonoffending adolescents, it has not always been consistently found that they witness more violence than other juvenile offenders (Haapasalo & Hamalainen, 1996), especially other violent offenders (Spaccarelli et al., 1997). Therefore, it is quite possible that family violence and other detrimental family factors associated with the occurrence of domestic violence may be more generally linked to violent and aggressive behavior rather than to sex offending specifically. Second, there have been few attempts to explain the mechanisms through which family violence might place an adolescent at risk for committing sexual assaults or engaging in other types of violent offending. The focus on potential mediating factors is important for designing treatment programs to alter the adverse consequences of domestic violence.

One characteristic of adult sexual offenders, especially the most chronic and violent sex offenders, is the presence of traits associated with psychopathy (Rice, Harris, & Quinsey, 1990). Psychopathic

traits can be separated into two correlated dimensions of behavior (Hare, Hart, & Harpur, 1991; Harpur, Hare, & Hakstian, 1989). The first dimension is a callous and unemotional interpersonal style characterized by such traits as superficial charm, absence of empathy, absence of guilt, and shallow and constricted emotions. The second dimension is an impulsive and antisocial lifestyle characterized by such traits as repeated criminal acts, poor impulse control, boredom susceptibility, poor planfulness, short-term marital relationships, and failure to accept responsibility for actions. Although these two dimensions of psychopathy have primarily been investigated in adult samples, there have been studies investigating similar characteristics in samples of antisocial and delinquent youth (Frick, O'Brien, Wootton, & McBurnett, 1994; Frick, 1998). For example, youth who show callous and unemotional traits tend to show an especially severe and aggressive pattern of antisocial behavior (Christian, Frick, Hill, Tyler, & Frazer, 1997).

These dimensions associated with psychopathy have not been studied in a juvenile sex offender population and, more important, they have not been tested as potential mediators of the link between family violence and sexual assaults. There are several pieces of evidence to suggest that both dimensions of psychopathy could play such a mediating role. For example, one characteristic of men who abuse their spouses is a difficulty with impulse control (Arias & O'Leary, 1988). It is possible that this poor impulse control is transmitted to their sons, either through social learning mechanisms (Patterson & Capaldi, 1991) or through genetic mechanisms (Hur & Bouchard, 1997). This poor impulse control might then play a role in the adolescents' sexual offending. Indeed, an analysis of the criminal histories of adult males committed to the Massachusetts Treatment Center (MTC), a facility for sexual offenders, revealed that apprehension for a juvenile sex offense was significantly related to measures of impulsivity (Knight & Prentky, 1993). In addition, impulsivity was linked to significantly higher rates of recidivism in a sample of male rapists who had been previously committed to the MTC (Prentky, Knight, Lee, & Cerce, 1995).

The callous and unemotional style associated with psychopathy could also play a mediating role in the association between witnessing

domestic violence and sexual offending. For example, the temperamental variables that underlie the callous and unemotional personality traits may be transmitted across generations, leading to higher rates of domestic violence in the parents and greater susceptibility to violence in the offspring (Frick, 1998; Lykken, 1995). An alternative explanation is that exposure to violence in the home can desensitize a child to effects of the violence on the victim, making him or her more likely to victimize others (Widom, 1989).

It is possible that both dimensions of psychopathy could be related to the behaviors of sexual offenders or to violent offending in general (Christian et al., 1997; Hare et al., 1991). One potential mediator that may be specific to increased risk for sexual offending is the development of hostile and sexist attitudes toward women. Females constitute the majority of victims of juvenile sex offenses (Fehrenbach et al., 1986; Groth, 1977; Longo, 1982; Van Ness, 1984; Wasserman & Kappel, 1985) and adolescent sex offenders have been found to hold a number of false beliefs about female sexuality (Spaccarelli et al., 1997). For instance, many believe such myths as: Females are inviting sexual activity if they cross their legs and swing one while sitting; females are sexually aroused if they laugh during a discussion of sexual topics; and, when a female says "no," she really means "yes" (Lakey, 1992). Both adult (Porter, 1990) and juvenile (Spaccarelli et al., 1997) sex offenders minimize the amount of harm experienced by victims of rape. Furthermore, Stenson and Anderson (1987) noted that the vast majority of adolescent sex offenders hold a number of sexist beliefs, such as the idea that females are inferior to males in most ways, including general intellect; that females should obey males; and that females exist for the sexual gratification of males (see also Lakey, 1992).

The current study has two goals: (a) to replicate past research that has shown a high rate of domestic violence in the family histories of youthful sexual offenders and (b) to determine whether variables more characterological and/or attitudinal in nature seemed to explain the link between domestic violence and sexual offending. The first goal sought to clarify whether the association with domestic violence is specific to sexual offenders by comparing the histories of sexual offenders to those of other violent offenders and other nonviolent offenders. The second goal was to determine whether poor impulse

control, the presence of a callous and unemotional interpersonal style, or having sexist attitudes toward women seemed to explain the link between domestic violence and sexual offending. One common methodological shortcoming in previous research in this area is the combination of different types of sex offenders, such as rapists and voyeurs, in one sample (Davis & Leitenberg, 1987; Spaccarelli et al., 1997). The psychological profiles of these different types of sexual offenders, especially in terms of the presence of both dimensions of psychopathy, may be quite different (Hare et al., 1991; Rice et al., 1990). The current study avoided this methodological problem by including only sex offenders who committed contact crimes against their victims.

METHOD

PARTICIPANTS

The sample consisted of 69 juvenile males, ages 13 to 18 ($M = 16.18$; $SD = 1.08$). Twenty-three of these participants were sexual offenders, 17 were violent nonsex offenders, and 29 were noncontact offenders. All participants in the study were males who were recruited from a secure juvenile institution that was part of the State of Alabama's Division of Youth Services (DYS). Seventy-five males were in residence at the institution at the time the study was conducted. The secure facility from which participants were recruited is the only secure facility in the state of Alabama for juvenile sex offenders committed to DHS.

Offenders were classified into three categories based on their histories of recorded offenses. The sex offenders included in the study were only those who engaged in physical contact offenses with their victims. Violent offenders were those who committed contact, but nonsexual, offenses, such as assault or robbery. Noncontact offenders were juveniles who committed property offenses, such as theft and destruction of property or drug offenses. All of the contact sex offenders in the institution at the time of the study agreed to participate; three violent nonsex offenders and three noncontact offenders in the institution refused to participate.

TABLE 1: Demographic Characteristics of the Sample

	<i>Sexual Offenders (n = 23)</i>	<i>Violent Offenders (n = 17)</i>	<i>Noncontact Offenders (n = 29)</i>	<i>F (2, 67)</i>	<i>Total Offenders (N = 69)</i>
Age	15.37	16.59	16.47	9.67***	16.18
(SD)	(1.12)	(0.71)	(0.97)		(1.08)
IQ	79.57	81.88	83.63	0.99	81.87
(SD)	(13.43)	(9.36)	(8.10)		(10.42)
$\chi^2 (2, n = 69)$					
Race	7.43				
% African American	52.2	76.5	76.7		68.6
% Caucasian	43.5	23.5	20.0		28.6
% Hispanic	0.0	0.0	3.3		1.4
% Other	4.4	0.0	0.0		1.4
Victim gender	48.99***				
% Male	26.1	66.7	0.0		23.5
% Female	56.5	20.0	16.7		30.9
% Both	17.4	13.3	26.7		20.6
% Property/drug	0.0	0.0	56.7		25.0

NOTE: Age information was unavailable for 4 sex offenders. Information on victim gender was unavailable for 2 violent offenders. Means with different superscripts are significantly different ($p < .05$) using Duncan's procedure for making pairwise comparisons of means.

*** $p < .001$.

Table 1 summarizes the demographic characteristics of the three offender groups. The three groups did not differ in their self-reported ethnicity or on standardized measures of intelligence. There was a significant group difference on the age of the sample, $F(2, 67) = 9.67$; $p < .05$, with the sex offenders being somewhat younger than the other two offender groups. However, the maximum difference between groups was only 1.22 years. All analyses were conducted both controlling for age and without controlling for age. As would be expected given the restricted age range, controlling for age made minimal differences in the results of all analyses. Therefore, results are only reported for analyses without controlling for age. The groups also differed significantly on the gender of the victims. As expected from past research, the majority of sex offenders had only female victims in their offending histories (56%) and the majority of violent offenders had only male victims in their offending histories (67%, $\chi^2 [2, n = 69] = 48.99$, $p < .001$).

MEASURES

Conflict Tactics Scales, Form R (CTS). The CTS (Straus & Gelles, 1990) was designed to assess the various behaviors used by family members in conflict or anger situations. Consistent with past studies of juvenile offenders (e.g., Spaccarelli et al., 1997; Stets, 1991), the CTS was modified to be completed by the offenders about their parents' conflict tactics. Although the CTS contains several subscales, only the nine-item Violence scale was used in this study. This subscale was used to measure violence directed by a child's father or father-figure against his mother or mother-figure. The Violence items were divided into two categories: minor violence items (e.g., threw something at the other person; and pushed, grabbed, or shoved) and severe violence items (e.g., kicked, bit, or punched; hit or tried to hit with an object; beat up; choked; threatened with a gun or knife; and used a gun or knife). The Violence scale has been found to be a reliable and valid measure of domestic violence in past research (Resick & Reese, 1986; Straus & Gelles, 1990).

The distribution of CTS scores for severe violence was significantly skewed. Therefore, subjects were classified according to (a) whether they had witnessed any violence in the home (48% of sample) and (b) whether they had witnessed any acts of severe violence in the home (23%). In addition to the frequency with which a subject witnessed domestic violence, a question was added to the CTS to assess the time period over which this violence was witnessed. Of those in the sample who reported witnessing domestic violence ($n = 27$), the mean duration of the violence was 41 months.

Psychopathy Screening Device (PSD). The PSD (Frick & Hare, in press) is a 20-item rating scale designed to be a childhood extension of the Psychopathy Checklist-Revised (PCL-R; Hare, 1991), a widely used measure of psychopathy in adults. The PSD includes all the dimensions tapped by the PCL-R, with the exception of those not relevant to children or adolescents (e.g., irresponsible behavior as a parent and multiple marriages). All items on the PSD are rated on a 0 to 2 scale, with 0 = *not true at all*; 1 = *sometimes true*; and 2 = *definitely true*. Although the PSD was originally designed to be rated by

children's parents and teachers (Frick et al., 1994), a self-report version of the PSD was used in this study.

Similar to its adult counterpart, the PCL-R, the PSD has been found to contain two factors (Frick et al., 1994). Six items form a Callous/Unemotional (CU) factor that corresponds to the interpersonal and affective dimensions of psychopathy and assesses lack of guilt, absence of empathy, and emotional constrictedness. Ten items form an Impulsivity/Conduct Problems (I/CP) factor that corresponds to the impulsive and antisocial lifestyle dimension of psychopathy and assesses poor impulse control, boredom susceptibility, and antisocial behaviors. Scales based on these factors have been found to be internally consistent (Frick et al., 1994). In addition, the factors show correlations with external criteria such as intelligence and anxiety (Frick et al., 1994), a reward-oriented response style (O'Brien & Frick, 1996), and severity of behavior (Christian et al., 1997) that suggest that they are measuring constructs analogous to the two dimensions of psychopathy assessed by the PCL-R (Hare et al., 1991). Elevations on these scales were determined using a cut-off corresponding to the 95th percentile of a volunteer sample of children (O'Brien & Frick, 1996). This cut-off designates a level of psychopathic traits that not only is outside of a normative range but also designates antisocial children who show characteristics that are similar to adults with psychopathic traits (see Frick, 1998, for a review).

Sexist Attitudes Toward Women Scale (SATWS). The 40-item SATWS (Benson & Vincent, 1980) measures seven components of sexism toward women: attitudes that women are genetically inferior (biologically, emotionally, and intellectually) to men; support for the idea that men should have greater power and rights than women; support for anti-female sex discrimination in education, work, and politics; bitterness toward women who engage in traditionally masculine roles or behaviors or who fail to assume traditional female roles; lack of support and empathy for women's liberation movements and related issues; the employment of disparaging labels and stereotypes in describing women; and the evaluation of women based on physical attractiveness and the willingness to treat women as sexual objects. Scores on the SATWS are strongly related to other measures of

sexism, such as the Attitudes Toward Women Scale (Spence & Helmreich, 1972).

Marlowe-Crowne Social Desirability Scale (SDS). Because all of the measures were based on participants' self-reports, the SDS (Crowne & Marlowe, 1964) was used to assess the extent to which participants may have been subject to a response set in which their answers were influenced by a desire to portray themselves in a positive light. The SDS is a 33-item measure that includes such items as, "I am always courteous, even to people who are disagreeable," and "No matter who I'm talking to, I'm always a good listener." The mean on the SDS for the total sample of offenders in the study is 17.34 ($SD = 5.11$), which is comparable to results found with a sample of undergraduates (Crowne & Marlowe, 1964). More important, the three offender groups did not differ in their scores on the SDS, $F(2, 67) = 1.24, p = ns$, indicating that any group differences could not be attributable solely to differences in a socially desirable response set.

PROCEDURE

All participants were committed to the Division of Youth Services, which served as the youths' legal guardian and which, therefore, provided informed consent for their participation. Active informed assent was obtained from all participants and a passive assent procedure was used to obtain permission from each participant's parents. As part of the assent procedure, all participants were instructed on the purpose of the investigation and the procedures involved, including the review of their case records. They were also told that their participation was entirely voluntary and their decision to participate would in no way affect their length of commitment to DYS or their treatment by DYS staff. They were further informed that the measures they completed would not be provided to DYS staff and would only be used in research in ways that protected their anonymity. A pizza party was offered as incentive to participate.

After this informed assent, participants were tested in three groups of between 17 and 29 adolescents. They began by providing demographic information followed by the four study questionnaires that

TABLE 2: Comparisons of Three Offender Groups on Self-Reported Witnessing of Domestic Violence Against Mothers or Mother-Figures

	<i>Sexual Offenders</i> (n = 23)	<i>Violent Offenders</i> (n = 17)	<i>Noncontact Offenders</i> (n = 29)	χ^2 (2, n = 69)	<i>Total Offenders</i> (N = 69)
Witnessing of any violence	56.5%	47.1%	41.4%	1.18	47.8%
Witnessing of severe violence	34.8%	29.4%	10.3%	4.79*	23.2%
	(n = 13)	(n = 5)	(n = 9)	F (2, 24)	(n = 27)
Duration of violence in months (SD)	46.08 (54.06)	46.40 (61.86)	30.00 (51.23)	0.26	40.78 (52.96)

* $p < .10$.

were administered in the following standardized order: CTS, SATWS, PSD, and SDS. In addition to participants' offense histories that led to the main offender groups used in this study, participants' intelligence quotients (IQs) and the genders of their victims were obtained from their institutional records. IQ information was generally assessed with Wechsler instruments; some records, however, contained only IQ scores in the absence of instrument specificity.

RESULTS

The first set of analyses compared the three offender groups on their self-reported witnessing of domestic violence. The groups were compared on the proportion who had reported witnessing any domestic violence directed at their mothers or mother-figures, the proportion who had witnessed severe violence, and for those in each group who had witnessed any violence, the duration of the violence. The results of these analyses are reported in Table 2. In the total sample, 48% of all the offenders reported witnessing some level of domestic violence directed against their mothers. This percentage did not differ significantly across the three offender groups, ranging from 41% of the non-contact offenders to 57% of the sex offenders.

TABLE 3: Comparisons of Three Offender Groups on Potential Mediators of Domestic Violence

	<i>Sexual Offenders (n = 23)</i>	<i>Violent Offenders (n = 17)</i>	<i>Noncontact Offenders (n = 29)</i>	χ^2 (2, n = 69)	<i>Total Offenders (N = 69)</i>
Callous-unemotional	34.8%	5.9%	6.9%	9.15**	15.9%
Poor impulse control	26.1%	23.5%	24.1%	0.04	24.6%
	F (2, 67)				
Sexist attitudes (SD)	175.49 (30.11)	168.45 (19.62)	170.77 (35.01)	0.15	172.03 (29.42)

** $p < .01$.

There was greater divergence between the offender groups when the proportion witnessing severe domestic violence was studied. Roughly three times the number of participants in the sex offender (35%) and violent offender (29%) groups witnessed severe domestic violence than the noncontact offender group (10%), and the overall chi-square analysis approached significance, $\chi^2(2, n = 69) = 4.79, p < .09$. When the sex offender and violent offender groups were collapsed into a single contact offender group, the difference in the rate of severe violence witnessed by contact and noncontact groups reached statistical significance, $\chi^2(1, n = 69) = 4.63, p < .05$. Of those offenders who reported having witnessed domestic violence ($n = 27$), the mean duration of the violence did not differ significantly across offender groups, ranging from 30 months in the noncontact offender group to 46 months in both of the contact offender groups.

These analyses indicated that more offenders in both contact offender groups reported witnessing severe domestic abuse than the noncontact offender group. The next set of analyses was designed to test potential mediators between domestic violence and offender categories. These analyses are reported in Table 3. Overall, 25% of the sample showed elevated scores on the PSD Impulsivity/Conduct Problems (I/CP) scale and the percentage scoring in the elevated range did not differ across the three offender groups. In contrast, the rate of elevated scores on the Callous-Unemotional (CU) scale of the PSD was 16% in the sample, with the percentage of sex offenders showing

these traits (35%) being dramatically higher than the percentage in the violent offender (6%) and noncontact offender (7%) groups, $\chi^2(2, n = 69) = 9.15, p < .01$). The final analysis reported in Table 3 is the comparison of the three groups on the presence of sexist attitudes toward women. Contrary to predictions, scores on the measure of sexist attitudes toward women, the SATWS, were not significantly different across the three offender groups, $F(2, 67) = .15, p = ns$.

The results of these analyses were not consistent with a mediational role of poor impulse control, callous-unemotional traits, or sexist attitudes toward women in the relation between domestic violence and juvenile sex offending. Although both contact offender groups (sex offenders and violent offenders) reported witnessing more domestic violence directed at their mothers, there were no differences across the three offender groups on the measure of poor impulse control or on the measure of sexist attitudes toward women. Furthermore, only the sex offender group showed high rates of callous-unemotional traits. As a result, it was unlikely that these three potential mediators would be associated with witnessing severe domestic violence. To test this possibility explicitly, the offenders were divided into two groups: those who reported witnessing severe domestic violence ($n = 16$) and those who did not report witnessing this severe level of violence directed at their mothers ($n = 53$). The two groups were compared on the measures of poor impulse control, callous and unemotional traits, and sexist attitudes toward women. These analyses are reported in Table 4. As expected from previous analyses, there was no association between witnessing severe domestic violence and scores on any of these measures.

DISCUSSION

Interpretation of the results of this study need to be made in light of several limitations. First, all of the measures on which the three offender groups were compared in this study were based solely on the offenders' self-reports. Because the grouping of offenders into the three categories was based solely on file review, there was no confound between method of group formation and the source of information on which the groups were compared. However, it would have

TABLE 4: The Association Between Witnessing Severe Violence and the Presence of Callous-Unemotional Traits, Poor Impulse Control, and Sexist Attitudes

	<i>Witnessed Severe Violence (n = 16)</i>	<i>Witnessed No or Minor Violence (n = 53)</i>	χ^2 (2, n = 69)
Callous-unemotional	25.0%	13.2%	1.28
Poor impulse control	37.5%	20.8%	1.86
			t (df = 67)
Sexist attitudes (SD)	161.70 (42.93)	166.48 (23.26)	0.58

NOTE: None of the comparisons reached ($p < .05$) or approached ($p < .10$) statistical significance.

been preferable to have some assessment sources that were independent of the offenders' self-reports, such as familial corroboration of witnessed violence, to provide greater confidence in the validity of these measures. Second, the offender classification, because it was based solely on file review of official records, may not correspond to classifications made by other means, such as through self-reports of delinquent acts. However, when official records of juvenile offenders are compared to self-reports, few offenders who are not officially recorded as committing sexual offenses self-report committing sex offenses (8% to 20%), whereas a significant proportion of officially recorded sexual offenders do not self-report sexual offenses (37%) (Spaccarelli et al., 1997). Therefore, use of institutional records seems to be most accurate in designating sex offenders, many of whom may not admit to committing such offenses. However, it is possible that some offenders classified as either violent or noncontact offenders may have sexual offenses not documented by our file review.

Within the context of these limitations, the results of this study contribute to a growing body of research showing both commonalities and important points of divergence between different juvenile offender groups. Much of the early work on the families of juvenile offenders used normal control groups and clearly have shown that juvenile offenders come from more dysfunctional family backgrounds than

nonoffenders (see Loeber & Stouthamer-Loeber, 1986, for a review). However, such studies do not allow for tests of whether there are differences in family backgrounds across specific offender groups. Using different offender groups as controls allows for these tests of specific relations while controlling for an overall level of family dysfunction that characterizes juvenile offenders in general. Admittedly, comparisons across juvenile offender groups are more conservative; however, they are essential for testing potential mechanisms that may be specific to one type of offending behavior, such as the mechanisms proposed in this study.

Using this methodology, we found that juvenile offenders in general witness a high rate of domestic violence, and this finding did not differ across the type of offender category. However, our results are also consistent with those of Spaccarelli et al. (1997); that is, when definitions of domestic abuse are limited to severe forms of violence witnessed by the adolescent, both sex offenders and other violent offenders report a higher rate of domestic violence than noncontact offenders. It is not clear from these results whether this link between severe domestic violence and contact offending is indicative of an overall greater degree of family pathology in the histories of these two violent offender categories or whether the link is specific to severe family violence.

Our results were not consistent with the potential mediating role of poor impulse control, callous-unemotional traits, or sexist attitudes toward women for explaining the link between witnessing of domestic violence and contact offending. For example, poor impulse control was not specifically associated with the contact offending groups, the groups who witnessed the most severe domestic violence, but was equally distributed across the offender categories. Therefore, this aspect of psychopathy does not seem to be associated with a certain type of offending but seems to be related to juvenile offending in general. Similarly, holding sexist attitudes toward women was not specific to any single offender category, because all offenders showed a relatively high rate of sexist beliefs (Benson & Vincent, 1980).

One clear point of divergence between the three offender groups was in the high rate of callous and unemotional traits within the sex offender group, relative to both the violent and noncontact offender groups. This pattern does not support our original hypothesis that

these traits mediate the relation between witnessing domestic violence and sexual offending because the violent offender group, which witnessed severe domestic violence at a rate equal to the sex offender group, did not show high proportions of these traits. This finding is consistent with the link between psychopathic personality traits and violent sexual offending in adults (Rice et al., 1990) and it suggests that extending the concept of psychopathy to juvenile sex offenders may be useful.

This extension to juveniles could be useful for both understanding the causes of sex offending and developing more effective treatment programs for sexual offenders. For example, Moffitt, Caspi, Dickson, Silva, and Stanton (1996) found that an especially severe group of antisocial adolescents who show very stable patterns of delinquent behavior was characterized by impulsive and impetuous behavior combined with a cold, callous, alienated, and suspicious interpersonal style. These authors argued that these characteristics, which are consistent with the characteristics displayed by this study's sex offender group, are indicative of a more severe and characterological disturbance compared to that of other antisocial adolescents (see also Moffitt, 1993). The theoretical importance of these callous and unemotional traits for understanding the causes of sex offending also comes from research showing that youth characterized by these traits often have temperamental tendencies characterized by low behavioral inhibition, which make them less susceptible to normal socializing pressures and often lead to deficient internalization of guilt and empathy (Frick, 1998). If our results linking sexual offending to callous and unemotional traits are replicated, further research on the development of these traits and how they may be prevented or modified becomes critical for understanding and treating the deficits that may be specific to sex offenders.

In summary, our study provided results consistent with past research showing that contact offenders differ from nonviolent juvenile offenders in witnessing more severe domestic violence. Our results do not shed light on potential mediators of this relation because our hypothesized mediators did not adequately explain this relation in our sample of institutionalized juvenile offenders. Our results did, however, suggest that high rates of callous and unemotional traits may be characteristic of juvenile sex offenders. These traits are one part of

the construct of psychopathy, a construct that has a long history of use in adult prison settings to designate distinct groups of prisoners (Hare et al., 1991) but has not been employed extensively in juvenile settings. Our results suggest that the traits associated with the interpersonal and affective dimensions of psychopathy may be important for differentiating juvenile sex offenders from other offenders and, with further study, could provide the basis for treatment interventions that more specifically address the mechanisms underlying the behavior of many juvenile sex offenders.

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U.S. Department of Justice

Office of Justice Programs

Office of Juvenile Justice and Delinquency Prevention



JUVENILES WHO HAVE SEXUALLY OFFENDED

A REVIEW OF THE
PROFESSIONAL LITERATURE

OJJDP
REPORT

Office of Juvenile Justice and Delinquency Prevention

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) was established by the President and Congress through the Juvenile Justice and Delinquency Prevention (JJDP) Act of 1974, Public Law 93–415, as amended. Located within the Office of Justice Programs of the U.S. Department of Justice, OJJDP's goal is to provide national leadership in addressing the issues of preventing and controlling juvenile delinquency and improving the juvenile justice system.

OJJDP sponsors a broad array of research, demonstration, and training initiatives to improve State and local juvenile programs and to benefit private youth-serving agencies. These initiatives are carried out by seven components within OJJDP, described below.

Research and Program Development Division

develops knowledge on national trends in juvenile delinquency; supports a program for data collection and information sharing that incorporates elements of statistical and systems development; identifies the pathways to delinquency and the best methods to prevent, intervene in, and treat it; and analyzes practices and trends in the juvenile justice system.

Training and Technical Assistance Division provides juvenile justice training and technical assistance to Federal, State, and local governments; law enforcement, judiciary, and corrections personnel; and private agencies, educational institutions, and community organizations.

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Concentration of Federal Efforts Program promotes interagency cooperation and coordination among Federal agencies with responsibilities in the area of juvenile justice. The Program primarily carries out this responsibility through the Coordinating Council on Juvenile Justice and Delinquency Prevention, an independent body within the executive branch that was established by Congress through the JJDP Act.

Child Protection Division administers programs related to crimes against children and children's exposure to violence. The Division provides leadership and funding to promote effective policies and procedures to address the problems of missing and exploited children, abused or neglected children, and children exposed to domestic or community violence. CPD program activities include supporting research; providing information, training, and technical assistance on programs to prevent and respond to child victims, witnesses, and their families; developing and demonstrating effective child protection initiatives; and supporting the National Center for Missing and Exploited Children.

The mission of OJJDP is to provide national leadership, coordination, and resources to prevent and respond to juvenile offending and child victimization. OJJDP accomplishes its mission by supporting States, local communities, and tribal jurisdictions in their efforts to develop and implement effective, multidisciplinary prevention and intervention programs and improve the capacity of the juvenile justice system to protect public safety, hold offenders accountable, and provide treatment and rehabilitative services tailored to the needs of individual juveniles and their families.

Juveniles Who Have Sexually Offended

A Review of the Professional Literature

Report



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Foreword

Sex offenses committed by juveniles are a serious problem. Nearly 16 percent of the arrests for forcible rape in 1995 and 17 percent of the arrests for all other sex offenses in 1995 involved youth under the age of 18. Perhaps even more disturbing are the indications that one in two adult sex offenders began sexually abusive behavior as a juvenile.

The costs imposed by juvenile sex offending are considerable, not only those inflicted on crime victims and society as a whole, but also those imposed on offenders and their families.

As with other delinquent behaviors, early intervention can be critical. Unfortunately, many programs used to treat juveniles who have committed sex offenses appear to apply interventions derived from our knowledge of adult sex offenders without adequate attention to the unique developmental needs of youth.

The authors of *Juveniles Who Have Sexually Offended* have diligently mined the research literature to provide a comprehensive and annotated account of the characteristics of juveniles who commit sex offenses and their families, and the type of offenses they commit.

A broad array of clinical assessment tools, including psychological testing, are described, and a thorough discussion of recidivism rates and issues is presented. The Report concludes with a review of treatment approaches and settings and a look at program assessment.

Youth who have committed sex offenses both have developmental needs and pose unique risks related to their abusive behaviors. The information provided by the review of the professional literature presented in this Report should enable us to better address those needs and risks.

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This Report provides a convenient and up-to-date review of the literature and a discussion of the pragmatics of professional work with juveniles who have committed sex offenses. The authors hope that the review will assist caseworkers, clinicians, legal professionals, and others who work with these juveniles. Although this work often is difficult and challenging, combined efforts can make a difference.

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Executive Summary

Introduction

Sexual abuse is widely recognized as a significant problem in society, and the scope of the problem may be underestimated because juvenile sex offenders who are known to the system may represent only a small proportion of juveniles who have committed such offenses. Studies of adult sex offenders suggest another dimension of the problem: many of these offenders began their sexually abusive behavior in their youth.

The costs of sex offending are substantial for victims and society and for the young offenders and their families. To minimize these costs, timely and appropriate interventions are needed. A review of the professional literature suggests, however, that programs designed to meet the perceived needs of these young offenders frequently apply knowledge and interventions designed for adult offenders without considering developmental issues and needs unique to juveniles.

Characteristics of Juveniles Who Have Committed Sex Offenses

Juveniles who have committed sex offenses are a heterogeneous mix (Bourke and Donohue, 1996; Knight and Prentky, 1993). They differ according to victim and offense characteristics and a wide range of other variables, including types of offending behaviors, histories of child maltreatment, sexual knowledge and experiences, academic and cognitive functioning, and mental health issues (Knight and Prentky, 1993; Weinrott, 1996).

Offending Behaviors

Sexually abusive behaviors and sex offense characteristics. Sexually abusive behaviors range from noncontact offenses to penetrative acts. Offense characteristics include factors such as the age and sex of the victim, the relationship between victim and offender, and the degree of coercion and violence used.

Nonsexual criminal behavior. Juvenile sex offenders frequently engage in nonsexual criminal and antisocial behavior (Fehrenbach et al., 1986; Ryan et al., 1996). A national survey found that most of the 80 juveniles who disclosed sexually assaultive behavior had previously committed a nonsexual aggravated assault (Elliot, as cited in Weinrott, 1996).

Child Maltreatment Histories

The childhood experience of sexual abuse has been associated with juvenile sex offending (Fehrenbach et al., 1986; Kahn and Chambers, 1991; Kobayashi et al., 1995). Childhood experiences of being physically abused, being neglected, and witnessing family violence also have been independently associated with sexual violence in juvenile offenders (Kobayashi et al., 1995; Ryan et al., 1996). The abusive experiences of juvenile sex offenders, however, have not consistently been found to differ significantly from those of other juvenile offenders (Lewis, Shanok, and Pincus, as cited in Knight and Prentky, 1993; Spaccarelli et al., 1997). Research suggests that the role of child maltreatment in the etiology of sex offending is quite complex (Prentky et al., 2000).

Social and Interpersonal Skills and Relationships

Family factors. Factors such as family instability, disorganization, and violence have been found to be prevalent among juveniles who engage in sexually abusive behavior (Bagley and Shewchuk-Dann, 1991; Miner, Siekert, and Ackland, 1997; Morenz and Becker, 1995). Various studies (e.g., Kahn and Chambers, 1991; Fehrenbach et al., 1986; Smith and Israel, 1987) suggest that many juvenile sex offenders have experienced physical and/or emotional separations from one or both of their parents.

Social skills and relationships. Research repeatedly documents that juveniles with sexual behavior problems have significant deficits in social competence (Becker, 1990; Knight and Prentky, 1993). Inadequate social skills, poor peer relationships, and social isolation are among the difficulties identified in these juveniles (Fehrenbach et al., 1986; Katz, 1990; Miner and Crimmins, 1995).

Sexual Knowledge and Experiences

Sexual histories and beliefs. Research suggests that adolescent sex offenders generally have had previous consenting sexual experiences (Becker, Kaplan, Cunningham-Rathner, and Kavoussi, as cited in Knight and Prentky, 1993; Groth and Longo, as cited in Knight and Prentky, 1993; Ryan et al., 1996). Research also suggests that sometimes their previous experiences exceed those of juveniles who have not committed sex offenses (McCord, McCord, and Venden, as cited in Knight and Prentky, 1993). Prior experiences with sexual dysfunction, most commonly impotence or premature ejaculation, have also been reported in juvenile sex offenders (Longo, as cited in Knight and Prentky, 1993). A study of 1,600 juvenile sex offenders from 30 States (Ryan et al., 1996) found that only about one-third of the juveniles perceived sex as a way to demonstrate love or caring for another person; others perceived sex as a way to feel power and control (23.5 percent), to dissipate anger (9.4 percent), or to hurt, degrade, or punish (8.4 percent).

Deviant sexual arousal. Studies of male college students and adult sex offenders have shown that deviant sexual arousal is strongly associated with sexually coercive behavior (Barbaree and Marshall, as cited in Hunter and Becker, 1994; Earls and Quinsey, as cited in Hunter and Becker, 1994; Prentky and Knight, as cited in Knight and Prentky, 1993). Controlled studies of deviant sexual arousal in juvenile sex offenders are lacking. Two studies (Schram, Milloy, and Rowe, 1991; Kahn and Chambers, 1991) reported associations between sexual reoffending in juveniles and deviant sexual arousal, but both studies relied on clinical judgments rather than objective methods to identify deviant arousal.

Pornography. Investigations into the role of pornography in juvenile sex offending are limited in number. One study (Becker and Stein, as cited in Hunter and Becker, 1994) found that only 11 percent of the juvenile sex offenders studied said they did not use sexually explicit materials. Another study (Wieckowski et al., 1998) found that exposure to pornographic material at a young age was common in a sample of 30 male juveniles who had committed sex offenses. A comparative study (Ford and Linney, as cited in Becker and Hunter, 1997) found that 42 percent of juvenile sex offenders, compared with 29 percent of juvenile violent offenders (whose offenses were nonsexual) and status offenders, had been exposed to hardcore, sexually explicit magazines.

Academic and Cognitive Functioning

Academic performance. Studies typically report that as a group, juveniles who sexually offended experienced academic difficulties (Fehrenbach et al., 1986; Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997; Pierce and Pierce, as cited in Bourke and Donohue, 1996). One study (O'Brien, as cited in Ferrara and McDonald, 1996), however, found that 32 percent of a sample of male juvenile sex offenders had above-average academic performance.

Intellectual and cognitive impairments. Research that focuses on the intellectual and cognitive functioning of juveniles who have committed sex offenses is limited. Existing studies, however, suggest that intellectual and cognitive impairments are factors that should be addressed (Awad, Saunders, and Levene, as cited in Knight and Prentky, 1993; McCurry et al., 1998). Based on their review of the literature, Ferrara and McDonald (1996) concluded that between one-quarter and one-third of juvenile sex offenders have some form of neurological impairment.

Cognitive distortions and attributions. Knight and Prentky (1993) pointed out that some factors observed in abused children (e.g., reduced empathy, inability to recognize appropriate emotions in others, and inability to take another person's perspective) may have relevance for juvenile sex offenders who have been maltreated. This observation is consistent with research indicating that cognitive distortions, such as blaming the victim, are associated with sexual reoffending in juveniles (Kahn and Chambers, 1991; Schram, Milloy, and Rowe, 1991).

Mental Health Issues

Symptoms and disorders. Conduct disorder diagnoses and antisocial traits frequently have been observed in populations of juveniles who have sexually offended (Kavoussi, Kaplan, and Becker, 1988; Miner, Siekert, and Ackland, 1997). Studies also have described other behavioral and personality characteristics in juveniles who have sexually offended, such as impulse control problems and lifestyle impulsivity (Prentky and Knight, as cited in Prentky et al., 2000; Smith, Monastersky, and Deisher, as cited in Prentky et al., 2000). Carpenter, Peed, and Eastman (1995) found that juvenile sex offenders whose victims were younger children had higher scores on the Schizoid, Avoidant, and Dependent scales of the Millon Clinical Multiaxial Inventory (MCMI) than those whose victims were their age peers. Studies also have found higher rates of depression in juveniles who have sexually offended than in the general juvenile population (Becker et al., as cited in Becker and Hunter, 1997; Kaplan, Hong, and Weinhold, as cited in Becker and Hunter, 1997). Few studies of adolescents and children with sexual behavior problems report major psychopathology in the subjects and their families (Becker, as cited in Ferrara and McDonald, 1996; Johnson, as cited in Ferrara and McDonald, 1996).

Substance abuse. Studies vary widely on the importance of substance abuse as a factor in sex offending among juveniles. Lightfoot and Barbaree (1993) reported that rates at which juvenile sex offenders were found to be under the influence of drugs or alcohol at the time they committed their offenses ranged from 3.4 percent to 72 percent. Although substance abuse has been identified as a problem for many juveniles who have sexually offended (Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997), the role of substance abuse in sex offending remains unclear. Lightfoot and Barbaree pointed out that assessments of juvenile sex offenders should differentiate substance abuse problems from "normative" experimentation that is part of the developmental process. It appears that evidence is insufficient to identify substance abuse as a causative factor in the development of sexually abusive behavior, although substance abuse has a disinhibiting potential and, if present, may require intervention.

Types and Classifications

Types and Classifications of Male Adolescents Who Have Committed Sex Offenses

Although a variety of characteristics have been identified among juveniles who have sexually offended, few studies have attempted to classify these juveniles according to their similarities and differences. O'Brien and Bera (as cited in Weinrott, 1996) defined seven categories of juvenile sex offenders: naive experimenters, undersocialized child exploiters, sexual aggressives, sexual compulsives, disturbed impulsives, group influenced, and pseudosocialized. Graves (as cited in Weinrott, 1996) suggested three typologies: pedophilic, sexual

assault, and undifferentiated. Prentky et al. (2000) used six categories: child molesters, rapists, sexually reactive children, fondlers, paraphilic offenders, and unclassifiable. Weinrott (1998a) suggested four general types: juvenile delinquents in general, those who have deviant arousal, those who are psychopathic offenders, and those who fit none of these categories and may only require limited intervention. More research that differentiates juvenile sex offenders according to their various behavior patterns, cognitive and emotional functioning, and other relevant factors is needed to determine and apply appropriate and effective treatment strategies.

Sibling Incest

Few reports have specifically addressed issues pertaining to sibling incest. Araji (1997) noted that although sibling incest appears to be quite prevalent, often it is underreported and ignored. O'Brien (1991) compared sibling sex offenders with juvenile sex offenders whose victims were either children outside the family, adults, peers, or a mix of categories and found that the sibling offenders had more serious offending histories, were less likely to receive court-ordered treatment, and differed from the nonsibling offenders on several measures (including family factors such as presence of dysfunction and physical abuse). A study of inner-city minority juveniles (Becker et al., 1986), however, found that 9 of 22 sibling offenders also evidenced nonsibling paraphilic behavior. Bonner and Chaffin (1998) asserted that most interventions designed to address sibling sexual behavior assume a victim-perpetrator model but that such a model may not always be appropriate.

Girls Who Have Committed Sex Offenses

Incidence. Research on girls who have committed sex offenses has been relatively rare, and existing studies have been limited by small sample sizes and other factors. In their review of the literature, Lane and Lobanov-Rostovsky (1997) found that females represented 5–8 percent of juvenile sex offenders in three statewide incidence studies conducted in the 1980's. More recent studies, however, found a higher incidence of sex offending by young girls (English and Ray, as cited in Araji, 1997; Johnson, as cited in Lane and Lobanov-Rostovsky, 1997; Gray et al., 1997). The incidence of sex offending may be underestimated for female juveniles even more than for males, perhaps because of a societal reluctance (and even a reluctance among professionals) to acknowledge that girls are capable of committing such offenses (Travin, Cullen, and Protter, 1990).

Characteristics of female offenders and their offenses. Ray and English (1995) compared girls and boys in a sample of juveniles who were described as sexually aggressive. They found the girls tended to be younger than the boys and were less likely to have perpetrated acts of rape. The girls were more likely to be victims of sexual abuse, and more girls than boys had experienced multiple types of abuse. Fehrenbach and Monastersky (as cited in Bumby and Bumby, 1997) found that, in their sample, most adolescent girls who sexually victimized young children did so while engaged in a childcare situation. Studies of girls in inpatient settings (Bumby and Bumby, 1997; Hunter et al., as cited in Bumby and Bumby, 1997), although limited by small sample size, suggest that factors such as depression, suicidal ideation, anxiety, poor self-concept, and childhood sexual victimization are relevant for girls who commit sex offenses. In perhaps the largest study to date, Mathews, Hunter, and Vuz (1997) compared 67 girls and 70 boys who had histories of sex offending and found meaningful similarities and differences: the girls' offending behaviors were similar to the boys' in terms of types of offenses committed, and both tended to victimize young children of the opposite gender; but girls typically had more severe victimization experiences themselves.

Young Children Who Have Committed Sex Offenses

Incidence. In the 1980's, after the problem of adolescent sex offending gained attention, similar behaviors in preadolescent and younger children also were recognized. Recent surveys suggest an increase in the rate of

preadolescent children who evidence sexually abusive behaviors. This apparent increase may reflect a greater awareness of the problem. In an extensive review of the literature pertaining to children who have been sexually aggressive, Araj (1997) stressed that research in this area is in its infancy and noted that many findings are simply clinical observations.

Individual characteristics. Available studies (Araj, 1997) have reported sexual aggression in children as young as 3 and 4; the most common age of onset appears to be between 6 and 9. Girls were represented in much greater numbers among these children than among adolescents who have abused, and these girls often engaged in behaviors that were just as aggressive as the boys' actions. Victims of preadolescents tended to be very young (averaging between ages 4 and 7), most often were female, and typically were siblings, friends, or acquaintances. Preadolescents who have sexually abused have been found to have high rates of sexual victimization experiences (Johnson, as cited in Araj, 1997; Friedrich and Luecke, as cited in Araj, 1997; Araj, Jache, Tyrrell, and Field, as cited in Araj, 1997; Araj, Jache, Pfeiffer, and Smith, as cited in Araj, 1997; Bonner, Walker, and Berliner, as cited in Araj, 1997; Pithers et al., 1998b) and significantly higher rates of abuse and neglect victimization experiences than those found among their adolescent counterparts (English and Ray, as cited in Araj, 1997). These preadolescents have also been found to have frequent academic and learning difficulties and impaired peer relationships (Friedrich and Luecke, as cited in Araj, 1997; Pithers and Gray, as cited in Araj, 1997).

Family characteristics. Studies described by Araj (1997) also found that families of preadolescents who have sexually abused tended to be dysfunctional. Araj concluded, "The evidence . . . points to family interactions as a primary source of the problem" (p. 87). The importance of family factors is supported by research conducted by Pithers et al. (1998a) concerning the caregivers of 72 children with sexual behavior problems. The families of these children tended to be characterized by high levels of poverty, single parenting, sexual abuse, domestic violence, and parenting stress.

Comparative studies of preadolescents and adolescents who have committed sex offenses. English and Ray (as cited in Araj, 1997) studied 271 juveniles who sexually offended by comparing the preadolescents with the adolescents. Although the researchers found many similarities between the groups (e.g., previous aggressive behavior, psychiatric problems, and levels of intellectual functioning), there were significant differences in the nature of their offenses and in their attitudes about the offenses. The adolescents had higher rates of depressive symptoms and suicidal gestures, perhaps (as Araj suggested) reflecting developmental differences between the groups. Both groups had a moderate to moderately high number of risk factors associated with repeat offending; risk factors included various characteristics of the juveniles, their families and environments, and their victims. The preadolescent children's families, however, evidenced significantly more problems, and the younger children also had significantly higher levels of social isolation and current life stresses.

Types and classifications. Young children who have sexual behavior problems are a heterogeneous group. Descriptions of these children typically differentiate normative sexual behavior from a continuum of progressively excessive and abusive sexual behaviors (Araj, 1997; Johnson, 1991). For example, Johnson (1991) classified these children into four groups: normal sexual exploration, sexually reactive, extensive mutual sexual behaviors, and child perpetrators. Araj (1997) conceptualized a subgroup of children—"sexually aggressive children"—who are comparable to children in Johnson's child perpetrators group and are at the extreme end of a childhood sexual behavior continuum. In a study of 127 children ages 6–12 who had evidenced sexual behavior problems, Pithers et al. (1998b) identified five subtypes: sexually aggressive, nonsymptomatic, highly traumatized, abusive reactive, and rule breaker. (The Pithers et al. study appears to be the first attempt to develop empirically derived and clinically relevant classifications of these children.) Longitudinal studies following these children over time are lacking; therefore, it is not known whether childhood sexual behavior problems continue or, more accurately, which children persist in their sexual misconduct in adolescence and adulthood.

Juveniles With Developmental Disabilities and Mental Retardation Who Have Committed Sex Offenses

In one of the few studies focusing on adolescent sex offenders with mental retardation, Gilby, Wolf, and Goldberg (1989) found that the frequency of sexual behavior problems among these juveniles did not differ significantly from the frequency among juveniles with normal (defined by the authors as borderline or higher) intellectual functioning. The researchers did, however, document some differences in the sexual behavior patterns of the two groups: for example, the juveniles with mental retardation had a higher rate of sexual assaults against peers and were less likely to know their victims. Although this study is informative, additional research is needed to determine whether the findings can be generalized to other juveniles with mental retardation who have committed sex offenses.

Juveniles Who Have Committed Sex Offenses Versus Other Types of Offenses

Although research is limited, available studies suggest that juveniles who commit sex offenses and juveniles who commit other types of offenses share many characteristics (e.g., Miner and Crimmins, 1995). Most recently, a study of chronic delinquents (Spaccarelli et al., 1997) found no differences on any of the measured variables between 50 sex offenders and 106 juveniles arrested for violent but nonsexual offenses.

Assessment

Clinical Assessment

In view of the heterogeneous nature of juveniles who have sexually offended, comprehensive assessments of individuals are needed to facilitate treatment and intervention strategies. These include assessment of each juvenile's needs (psychological, social, cognitive, and medical), family relationships, risk factors, and risk management possibilities.

Gathering multiple sources of information. Parents or guardians of juveniles should be involved in the assessment and in the treatment process (Morenz and Becker, 1995). Their informed consent should be obtained, and they should be clearly informed of the limits of confidentiality (Becker and Hunter, 1997). Comprehensive assessments should include clinical interviews with the juveniles and family members, a psychological assessment, and, in certain cases (according to some), phallometric assessment (Bonner et al., 1998; Morenz and Becker, 1995; Becker and Kaplan, 1993). Evaluators should review victim statements, juvenile court records, mental health reports, and school records as part of their assessment (Becker and Hunter, 1997).

Using psychological tests. Psychological tests have been described as adding a "critical dimension" to comprehensive evaluations of juveniles who have sexually offended (Kraemer, Spielman, and Salisbury, 1995). Bourke and Donohue (1996) observed that studies consistently reveal the heterogeneity of these juveniles and cited a wide range of coexisting psychological disorders to emphasize the importance of using comprehensive, standardized methods of assessment. Kraemer, Spielman, and Salisbury (1995) described four primary domains that require assessment: intellectual and neurological, personality functioning and psychopathology, behavioral, and sexual deviance.

Assessing deviant sexual arousal. To adequately assess individuals who appear to evidence deviant arousal, Weinrott (1998a) stressed the importance of using direct measurement of an individual's sexual arousal, through phallometric assessment. Others, however, have discussed potential ethical concerns related to using phallometric assessment with juveniles (Bourke and Donohue, 1996; Cellini, 1995). Weinrott (1998a) suggested ways of addressing these issues. Another psychophysiological assessment measure used with juveniles who have sexually offended is the Abel Assessment for Interest in Paraphilias (Abel Screening, Inc., 1996).

The Abel Assessment is significantly less invasive than phallometric assessment, and research conducted by the test developers has shown good results. However, an independent study of the Abel Assessment's reliability and validity raised questions about the use of this assessment approach with juveniles at this time (Smith and Fischer, 1999). The Abel Assessment is relatively new, and additional independent, published research is needed.

Substance abuse assessment. Assessment of a juvenile who has committed a sex offense needs to determine whether the juvenile has a substance abuse problem and, if so, whether it is a risk factor for that juvenile's sex offending. Researchers and clinicians have emphasized the importance of using valid and reliable assessment tools to screen for substance abuse problems (Becker and Hunter, 1997; Lightfoot and Barbaree, 1993).

Polygraph tests. Although controversial, the use of polygraph tests in treatment programs for juveniles who have been sexually abusive is increasing (National Adolescent Perpetrator Network [NAPN], 1993). The polygraph is used to facilitate more complete disclosures of sexually abusive behaviors and to monitor compliance with treatment. The National Task Force on Juvenile Sexual Offending has emphasized that polygraphs must be administered on a voluntary basis and with informed consent (NAPN, 1993). Research regarding the reliability and validity of the polygraph for assessing juveniles who have committed sex offenses is very limited (Hunter and Lexier, 1998), and some researchers have seriously questioned its validity (Cross and Saxe, as cited in Bonner et al., 1998; Saxe, Dougherty, and Cross, as cited in Bonner et al., 1998).

Risk Assessment

Few empirical studies have investigated sexual reoffense rates among juveniles or risk factors associated with recidivism. Two retrospective studies that investigated the frequency of offenses prior to the referral offense found relatively high offense rates (Awad and Saunders, 1991; Fehrenbach et al., 1986).

Rates of recidivism. The results of research investigating recidivism after juveniles were referred for sex offenses typically reveal relatively low rates of sexual recidivism (8 to 14 percent) (Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997; Rasmussen, 1999; Schram, Milloy, and Rowe, 1991; Sipe, Jensen, and Everett, 1998; Smith and Monastersky, 1986). The studies also find higher rates of nonsexual recidivism (16 to 54 percent). Methodological variations clearly influence recidivism rates (Prentky et al., 1997). Nevertheless, in an extensive review of studies investigating recidivism rates among juvenile sex offenders, Weinrott (1996, p. 67) noted: "What virtually all of the studies show, contrary to popular opinion, is that relatively few [juvenile sex offenders] are charged with a subsequent sex crime."

Factors associated with recidivism. Various studies have described characteristics identified in juveniles who have sexually offended. However, Weinrott (1998b) reported that very few characteristics have actually been empirically associated with sexual recidivism. He noted that these characteristics include the following: psychopathy, deviant arousal, cognitive distortions, truancy, a prior (known) sex offense, blaming the victim, and use of threat/force. Weinrott also reported that, contrary to common belief, factors such as social skills deficits, lack of empathy, or denial of offense or sexual intent either have not been empirically associated with sexual recidivism or have simply not been investigated. (This is not to say that interventions designed to address such factors, such as efforts to reduce social skills deficits or educate offenders about victim impact, are not effective in reducing sexual recidivism, only that there is no empirical evidence indicating they are effective.)

Prediction of recidivism. Chaffin and Bonner (1998) pointed out that there are no true experimental studies comparing untreated and treated juvenile sex offenders and no prospective studies evaluating risk factors or the natural course of sexual offending. Studies suggest that treatment providers may tend to overpredict sexual recidivism rather than risk the dire consequences associated with failing to predict recidivism that comes to pass. Factors limiting the accuracy of recidivism predictions include the relative infrequency and hidden

nature of sex offending, too-short followup periods, and insufficient or inadequate information relevant for decisionmaking. To enhance predictive accuracy, professionals should balance historical and actuarial information with clinical and situational information (Smith and Monastersky, 1986; Webster et al., 1997). Prentky et al. (2000) have developed and conducted initial testing of an actuarial risk assessment schedule designed to evaluate the risk of reoffending among juvenile sex offenders. As Epps (1994) noted, potential problems in using risk assessment tools to predict juvenile sex offenders' likelihood of reoffending include difficulties in gathering reliable and valid information upon which to base such instruments.

Treatment

The National Task Force on Juvenile Sexual Offending articulated a set of assumptions intended to reflect the current thinking relevant to a comprehensive systems response to juveniles who have sexually offended (NAPN, 1993). These assumptions are summarized below:

- ◆ Following a full assessment of the juvenile's risk factors and needs, individualized and developmentally sensitive interventions are required.
- ◆ Individualized treatment plans should be designed and periodically reassessed and revised. Plans should specify treatment needs, treatment objectives, and required interventions.
- ◆ Treatment should be provided in the least restrictive environment necessary for community protection. Treatment efforts also should involve the least intrusive methods that can be expected to accomplish treatment objectives.
- ◆ Written progress reports should be issued to the agency that has mandated treatment and should be discussed with the juvenile and parents. Progress "must be based on specific measurable objectives, observable changes, and demonstrated ability to apply changes in current situations" (NAPN, 1993, p. 53).
- ◆ Although adequate outcome data are lacking, NAPN (1993) suggests that satisfactory treatment will require a minimum of 12 to 24 months.

Some individual States also have worked to develop appropriate protocols and standards for effective interventions with juveniles who have committed sex offenses. Treatment programs for these juveniles have proliferated during the past decade, increasing from approximately 20 in 1982 (NAPN, 1988) to more than 680 in 1994 (Freeman-Longo et al., 1994).

Continuum of Care Models

To adequately address both the needs of individual juveniles who have committed sex offenses and the needs of the community, a continuum of care is recommended (Bengis, 1997; NAPN, 1993). Offering a range of interventions and placement options makes it possible to provide cost-effective interventions while placing paramount importance on community safety. Suggested components of such a continuum have been described in the *Oregon Report on Juvenile Sex Offenders* (Avalon Associates, 1986) and also by Bengis (1997) and the Utah Task Force of the Utah Network on Juveniles Offending Sexually (1996). Bengis pointed out that at different points during their treatment, juveniles may require different levels of supervision and treatment intensity. Bengis also stressed that to be most effective, the components of the continuum should have consistent treatment philosophies and approaches and should provide stability in treatment providers as the juvenile moves along the continuum.

Treatment Approaches

Overview. Primary goals in the treatment of juveniles who have sexually offended have been defined variously as community safety (NAPN, 1993), helping juveniles gain control over their abusive behaviors and increase their prosocial interactions (Cellini, 1995), and preventing further victimization, halting development of additional psychosexual problems, and helping juveniles develop age-appropriate relationships (Becker and Hunter, 1997). To accomplish these goals, highly structured interventions are recommended (Morenz and Becker, 1995). Treatment approaches include individual, group, and family interventions. Although group therapy often is described as the treatment of choice and cotherapy teams also are recommended (NAPN, 1993), empirical evidence of the superiority of these approaches is lacking. Advantages and disadvantages of these approaches have been described elsewhere (e.g., Marshall and Barbaree, 1990; Henggeler, Melton, and Smith, 1992). The first step in treatment typically involves helping the juvenile accept responsibility for his or her behavior (Becker and Hunter, 1997). Recommended treatment content areas typically include sex education, correction of cognitive distortions (cognitive restructuring), empathy training, clarification of values concerning abusive versus nonabusive sexual behavior, anger management, strategies to enhance impulse control and facilitate good judgment, social skills training, reduction of deviant arousal, and relapse prevention (Becker and Hunter, 1997; Hunter and Figueredo, 1999; NAPN, 1993). Many other relevant interventions also have been documented. Leaders in the treatment field have argued that programs designed to focus exclusively on sex-offending behaviors are of limited value and have recommended a more holistic approach (Goocher, 1994).

Addressing deviant arousal. Most programs that address deviant arousal do so through covert sensitization, a treatment approach that teaches juveniles to interrupt thoughts associated with sex offending by thinking of negative consequences associated with abusive behavior (Becker and Kaplan, 1993; Freeman-Longo et al., 1994). Other techniques include various forms of behavioral conditioning and are much more invasive and aversive. Such techniques raise concerns regarding practicality, effectiveness, and/or ethics. Vicarious sensitization (VS) is a relatively new technique that involves exposing juveniles to audiotaped crime scenarios designed to stimulate arousal and then immediately showing a video that portrays the negative consequences of sexually abusive behavior. Preliminary research findings suggest VS may be an effective approach for reducing deviant arousal in juveniles who are sexually aroused by prepubescent children (Weinrott, Riggan, and Frothingham, 1997).

Involving families. Rasmussen (1999) argued that adequate family support can help reduce recidivism and that treatment programs that involve families are likely to be more effective than others that do not. As Gray and Pithers (1993) observed, however, families vary in terms of their motivation and ability to effectively facilitate their child's treatment. Gray and Pithers described strategies that can engage the cooperation of family members and reported approaches that parents found useful.

Using a relapse prevention model. Gray and Pithers (1993) applied relapse prevention to the treatment and supervision of children and adolescents with sexual behavior problems. This technique requires that juveniles learn to identify factors associated with an increased risk of sex offending and use strategies to avoid high-risk situations or effectively manage them when they occur. When relapse prevention is applied to children, greater emphasis is placed on external supervision to prevent further victimization. Empirical studies investigating the effectiveness of this approach are lacking.

Summary. Some of the interventions described above appear appropriate for some juveniles who have committed sex offenses, but others do not. Furthermore, many of the target areas described are relevant not only for sex offenders but also for juveniles who commit other types of offenses. In view of the many studies identifying general delinquency and antisocial attitudes and behavior among juveniles who exhibit sexual behavior problems, Weinrott (1998a) suggested that relevant empirically based treatment interventions for juvenile delinquents be used with those who have committed sex offenses.

Research on Treatment Efficacy

Specialized treatment for juveniles who have committed sex offenses. Programs specifically designed for juveniles who have sexually offended have proliferated, but evaluation of these specialized approaches has been limited. For example, most programs have learning about the “sexual assault cycle” at their core, but despite the fact that the sexual assault cycle has been in use in sex offender treatment for nearly 20 years, the model has not been empirically validated (Weinrott, 1996). Chaffin and Bonner (1998) cautioned against the “conviction” that those working in the field have found the right approach and summarized the beliefs about sex-offense-specific interventions that may be included in such “dogma.” Chaffin and Bonner (1998) and Weinrott (1996) have observed that it currently is not possible to say whether one type of treatment is better than another, with the possible exception that delinquency-focused multisystemic treatment appears to be more effective than individual counseling with juveniles who have committed sex offenses. A study by Lab, Shields, and Schondel (1993) appears to raise questions about the efficacy of specialized treatment for juveniles who have committed sex offenses. A study by Kimball and Guarino-Ghezzi (1996), however, found that juvenile sex offenders placed in sex-offense-specific treatment demonstrated more positive attitudes and greater skill acquisition than those in nonspecific treatment. (Juveniles in sex-offense-specific treatment, however, received more intensive and varied interventions than those in non-offense-specific treatment.)

Treatment for juveniles who are delinquent. Research has been conducted to assess the effectiveness of interventions with juveniles who commit various types of offenses, not just sex offenses. Because general delinquency and antisocial attitudes and behavior are frequently found in juveniles who have committed sex offenses, these treatment approaches may be relevant and effective with these juveniles. Izzo and Ross (1990) conducted a meta-analysis of rehabilitation programs designed for all juvenile delinquents, not just those who have committed sex offenses. Their findings suggest that programs based on cognitive therapy were twice as effective as those using other approaches. More recently, Lipsey and Wilson (1998) conducted a meta-analysis of 200 experimental or quasi-experimental studies to assess the effectiveness of treatment interventions used with juvenile offenders. They found that among noninstitutionalized juveniles, treatments that focused on interpersonal skills and used behavioral programs consistently yielded positive effects. Other interventions that have been validated with chronic delinquents, such as multisystemic therapy and multidimensional treatment foster care, also are promising approaches for juveniles who have committed sex offenses (Borduin et al., 1990; Chamberlain and Reid, 1998; Swenson et al., 1998).

Attrition from sex-offense-specific treatment. Several studies of sex offender treatment programs have demonstrated high rates of treatment dropouts (Becker, 1990; Hunter and Figueredo, 1999; Kraemer, Salisbury, and Spielman, 1998; Rasmussen, 1999; Schram, Milloy, and Rowe, 1991). High rates of treatment attrition are extremely important. A study of juvenile sex offenders (Hunter and Figueredo, 1999) and several studies of adult offenders (e.g., Hanson and Buissière, 1998) suggest that failing to complete treatment is associated with higher rates of recidivism for both sex offenses and other types of offenses.

Treatment Setting

Segregating versus integrating juveniles who have committed sex offenses. Historically, treating juveniles who have committed sex offenses in a setting specifically designed for sex offenders has been considered “optimal” (Morenz and Becker, 1995). The literature, however, indicates that the effectiveness of this approach has not been proven. In fact, some studies suggest that other approaches may be more beneficial. Milloy (1994) indicated that no controlled studies have been published investigating the effect of segregating juvenile sex offenders from the general delinquent population. Whether juveniles who have been sexually abusive should be grouped with juveniles who have committed nonsexual offenses or with juveniles who have other behavioral problems is a complex issue. Arguments exist both for and against the use of segregated treatment units. In the meantime, the importance of individualized assessment and treatment planning cannot be overemphasized.

Facilitating safety in residential treatment settings. The issue of community safety exists regardless of whether a juvenile sex offender remains in the community or is placed in a segregated or unsegregated residential facility. NAPN (1993) provided specific recommendations to facilitate safety in residential treatment facilities.

Special Populations

Treatment of young and preadolescent children with sexual behavior problems. Gray and Pithers (1993) suggested that sexually abusive behaviors in children might be most effectively addressed by targeting risk factors that predispose a child to sexual behavior problems or that precipitate or perpetuate the problems. Araji (1997) described 10 treatment programs and practices for children with sexual behavior problems. All of the programs reviewed by Araji included cognitive-behavioral approaches; treatment modalities involved individual, group, pair, and family therapy (most providers appeared to prefer group therapies). Important factors when intervening with children who have been sexually abusive include addressing developmental issues and involving parents and other caregivers. As noted above, Pithers et al. (1998b) identified five subtypes of children with sexual behavior problems. Their investigations also revealed some differences in how children in various subtype classifications responded to different types of treatment.

Treatment of juveniles with cognitive or developmental disabilities. Special interventions may be necessary for juveniles with intellectual and cognitive impairments. For example, individuals with learning difficulties may not respond well to therapies (such as cognitive-behavioral approaches) that resemble their negative experiences in the classroom. A review of the literature (Stermac and Sheridan, 1993) found a dearth of research on treatment of adults and adolescents with developmental disabilities. Most studies have focused on adult offenders and have stressed behaviorally oriented interventions, and most interventions involving adolescents with developmental disabilities who have committed sex offenses have used approaches modified from adult treatment programs. Langevin, Marentette, and Rosati (1996) urged treatment professionals to reach out to these juveniles and suggested steps for doing so. Ferrara and McDonald (1996) provided a detailed discussion of treatment strategies and techniques that may be useful.

Training and Qualifications of Treatment Providers

Individuals providing treatment for juveniles with sexual behavior problems must be personally and professionally qualified (Association for the Treatment of Sexual Abusers, 1997a; NAPN, 1993). Personal qualifications include being emotionally healthy, having respect for oneself and others, using good listening skills, and having the ability to empathize. Professional qualifications include relevant education, training, and experience. Treatment providers should receive appropriate training before they begin their work and thereafter on a continuing basis. Working with juveniles who have sexual behavior problems is a challenging job. As NAPN (1993) observed, "Systems must be aware of potential emotional/psychological impacts on providers and take steps to protect against or counter negative effects" (p. 46).

Program Evaluation

Adequate program evaluation involves at least two primary approaches: (1) implementation research to ensure that the components necessary for effective treatment exist and are implemented and (2) outcome research to determine whether the interventions have been effective. Although the importance of program evaluation cannot be overemphasized, evaluations of sex offender treatment programs have been few, and those that have been conducted often have had inadequate designs (Camp and Thyer, 1993). Most outcome studies have used recidivism rates to assess treatment effectiveness, but several problems (generally low rates of recidivism, short followup periods, variability in outcome measures, and other methodological problems) limit the usefulness of

this approach. Other approaches to assessing treatment effectiveness are required. Two studies have used self-report measures to evaluate treatment effectiveness (Hains et al., as cited in Camp and Thyer, 1993; Miner, Siekert, and Ackland, 1997). Laben, Dodd, and Sneed (1991) used goal attainment theory to develop measurable outcomes in an inpatient juvenile sex offender treatment program. This approach required treatment providers and clients to establish mutual goals through a process of bargaining, negotiating, identifying commonalities, and defining measurable outcomes.

Conclusions

The findings of this literature review indicate that juveniles who have committed sex offenses are a heterogeneous group who, like all juveniles, have developmental needs, but who also have special needs and present special risks related to their abusive behaviors. Existing studies suggest that a substantial proportion of these juveniles desist from committing sex offenses following the initial disclosed offense and intervention.

The literature clearly supports the importance of interventions that are tailored to the individual juvenile. Risk management strategies likely to be most effective are those that address the needs underlying a juvenile's behavior and make the most of the juvenile's existing strengths and positive supports. Although efficacy has not been established for many sex offender interventions considered standard and required, there are a wide range of interventions with more of an empirical basis, particularly within the juvenile delinquency field (such as multisystemic therapy), that may be effective. It also should be remembered that some juveniles may require minimal interventions once their sex offending has been disclosed. An additional—and important—caution is that treatment efforts should not be harmful.

Lastly, it should be remembered that although the goal when working with juveniles who have committed sex offenses is to help them stop their abusive behaviors, they are children and adolescents first. They are young people who have committed offenses and who deserve care and attention.

Introduction

Sexual abuse is widely recognized as a significant problem in society. Juveniles¹ who commit sex offenses have victimized many people. Federal Bureau of Investigation data (as cited in Sipe, Jensen, and Everett, 1998) indicate that in 1995, 15.8 percent of arrests for forcible rape and 17 percent of arrests for all other sex offenses involved persons under 18 years old. Furthermore, Becker, Cunningham-Rouleau, and Kaplan (as cited in Prentky et al., 2000) reported that 79 percent of their sample of juvenile sex offenders had been arrested for a prior sex offense. Similarly, Groth (as cited in Prentky et al., 2000) found that nearly 75 percent of his sample of juvenile sex offenders had committed a prior sexual assault.

Studies of adult sex offenders (who were assured that the information they provided would remain confidential) also support the conclusion that sexual abuse by juveniles is a serious problem. This research suggests that approximately half of these individuals began their sexually abusive behavior before adulthood (Abel, Mittelman, and Becker, 1985; Groth, Longo, and McFadin, 1982; Saylor, as cited in Smith and Monastersky, 1986). Studies of

¹ Historically, most studies have focused on males, although some, particularly those that describe the characteristics of juveniles who commit sex offenses, have also included females. In this review, among the studies specifying that both males and females were included (or publications citing such studies) are the following: Becker and Hunter, 1997; Bourke and Donohue, 1996; Bumby and Bumby, 1997; English and Ray (as cited in Araj, 1997); Fehrenbach et al., 1986; Fehrenbach and Monastersky (as cited in Bumby and Bumby, 1997); Hunter, Lexier, Goodwin, Browne, and Dennis (as cited in Bumby and Bumby, 1997); Johnson (as cited in Lane and Lobanov-Rostovsky, 1997); Kahn and Chambers, 1991; Gray et al., 1997; Lane and Lobanov-Rostovsky, 1997; Mathews, Hunter, and Vuz, 1997; McCurry et al., 1998; Morenz and Becker, 1995; Ray and English, 1995; Righthand, Hennings, and Wigley, 1989; Ryan et al., 1996; Smith and Israel, 1987; and Weinrott, 1996.

juveniles and adults who committed sex offenses as juveniles indicate that juvenile sex offending includes a wide range of sexual misconduct. Offenses included noncontact sexual behaviors (such as exhibitionism and voyeurism), child molestation, and rape (Abel, Osborn, and Twigg, 1993; Righthand, Hennings, and Wigley, 1989). Research has shown that the sexual behavior problems exhibited by these juveniles are “not simply isolated incidents involving normally developing adolescents” (Fehrenbach et al., 1986, p. 231).

The scope of the problem may be underestimated because juvenile sex offenders who become known to the system may represent only a small proportion of juveniles who have committed such offenses. Knight and Prentky (1993) found that only 37 percent of the adult sex offenders in their sample had official records documenting juvenile sex offending histories. In contrast, when these subjects completed a computer-generated questionnaire and were assured that their responses would remain confidential, 55 percent acknowledged engaging in sexually abusive behavior as juveniles.

The importance of early intervention with juveniles who evidence sexual behavior problems cannot be overstated. As noted by Abel, Osborn, and Twigg (1993)—

If an individual begins to engage in such behaviors and is not subject to intervention and/or negative consequences for such actions, he will be reinforced by the innate positive reinforcers of the sexual act. These inherent positive reinforcers include, but are not limited to, the pleasure of orgasm, the pleasure of stress reduction, and the feeling of power the individual may feel over another person. (p. 15)

The costs of sex offending are substantial for victims and society and for the young offenders and their families. In addition to the human costs in terms of emotional and physical anguish and suffering, staggering financial costs are incurred as a result of child welfare and juvenile and criminal justice system involvement, therapeutic intervention, and so forth (Prentky and Burgess, 1990). To minimize these costs, timely and appropriate interventions are needed.

A review of the professional literature suggests that developers of programs to meet the perceived needs of these young offenders frequently have applied knowledge and interventions designed for adult offenders without considering the developmental issues and needs unique to juveniles. Only recently have a growing number of professionals pointed to the empirical literature to emphasize that, especially when it comes to juveniles, research has not supported the notion that “once a sex offender, always a sex offender” (Association for the Treatment of Sexual Abusers, 1997b; Becker, 1998). The longitudinal research necessary to conclusively support such a hypothesis has not been conducted (Becker, 1998).

In addition, there are important distinctions that differentiate juveniles from adult sex offenders (Association for the Treatment of Sexual Abusers, 1997b; Becker, 1998; Bonner, 1997). In fact, the appropriateness and ethics of the term “juvenile sex offender” have been called into question (Bonner, 1997). Language describing these young people as children or teenagers who have been sexually abusive (rather than as juvenile sex offenders) holds them accountable for their behavior yet does not suggest that they are and always will be disreputable sex offenders. Language that emphasizes the behavior rather than the person may help to avoid self-fulfilling prophecies that can contribute to offending behavior by promoting the belief that a person can never be more than his or her past. When the past includes sex offending, this can be a hopeless and esteem-deflating perspective.

Because most papers and studies in the literature have used the term “juvenile sex offenders,” this term will be used, at times, in this review. Yet, it is important to consider the impact of language and begin to make appropriate changes.

Characteristics of Juveniles Who Have Committed Sex Offenses

Juveniles who have committed sex offenses are a heterogeneous mix (Bourke and Donohue, 1996; Knight and Prentky, 1993). They vary according to victim and offense characteristics. They also differ on a wide range of other variables, including types of offending behaviors, histories of child maltreatment, sexual knowledge and experiences, academic and cognitive functioning, and mental health issues (Knight and Prentky, 1993; Weinrott, 1996).

In spite of the apparent heterogeneity of juveniles who have sexually offended, findings from the few existing studies that compared juveniles who committed sex offenses with those who committed other types of offenses frequently have not revealed significant differences between samples (Becker and Hunter, 1997). This finding may suggest that a substantial number of juvenile sex offenders may not differ significantly from other juvenile offenders, although subgroups of juveniles who committed sex offenses do differ from juveniles who committed other offenses. Subgroups of juveniles who committed sex offenses are discussed in more detail in the section on Types and Classifications.

Offending Behaviors

Sexually Abusive Behaviors and Sex Offense Characteristics

As noted above, sexually abusive behaviors range from noncontact offenses to penetrative acts. In a study of Maine juveniles identified as having committed sex offenses (Righthand, Hennings, and Wigley, 1989), more than half of the abusive acts involved oral-genital contact or attempted or actual vaginal or anal penetration.

Offense characteristics include factors such as the age and sex of the victim, the relationship between the victim and the offender, and the degree of coercion and violence used. See table 1 for details of offense characteristics.

Nonsexual Criminal Behavior

Juvenile sex offenders frequently engage in nonsexual criminal and antisocial behavior (Fehrenbach et al., 1986; Ryan et al., 1996). Such behavior may, in fact, be quite typical of juvenile sex offenders, especially those who engage in forcible sexual assaults such as rape and attempted rape. In a national survey, Elliott (as cited in Weinrott, 1996) found that most of the 80 juveniles who disclosed sexually assaultive behavior had previously committed a nonsexual aggravated assault, whereas relatively few (7 percent) had perpetrated exclusively sex offenses. Nonsexual (violent and nonviolent) criminal behavior is correlated with repeated sexual violence by adult sex offenders (Chaffin, 1994; Hanson and Buissière, 1996) and may also be an important risk factor for repeated sex offending by juveniles.

Child Maltreatment Histories

The childhood experience of sexual abuse has been associated with juvenile sex offending (Fehrenbach et al., 1986; Kahn and Chambers, 1991; Kobayashi et al., 1995). Rates of juvenile sex offenders who have experienced sexual abuse as children reportedly range from 40 to 80 percent (Becker and Hunter, 1997). Yet, such abusive experiences of juvenile sex offenders have not consistently been found to differ significantly from those of other juvenile offenders (Lewis, Shanok, and Pincus, as cited in Knight and Prentky, 1993; Spaccarelli et al., 1997). Furthermore, Smith and Monastersky (1986)

Table 1: Sex Offense Characteristics

Domain	Characteristic
Victim Characteristics	<ul style="list-style-type: none"> ◆ Female children are targeted most frequently.^{a,b,c,d,e,f,g,h} ◆ Male victims represent up to 25 percent of some samples.^{e,h,i}
Relationship Characteristics	<ul style="list-style-type: none"> ◆ Victims are more often substantially younger than the offender, rather than peer age.^{a,b,c,d,e,f,g,h,i} ◆ Victims are usually relatives or acquaintances; rarely are they strangers.^{a,e,f,g,h,i} ◆ Babysitting frequently provides the opportunity to offend.^{b,h}
Use of Aggression	<ul style="list-style-type: none"> ◆ Although juvenile sex offenders usually are less physically violent than adult offenders, they may secure the victim's compliance via intimidation, threats of violence, physical force, or extreme violence.^{a,j} ◆ Approximately 40 percent of the juveniles from a sample of 91 displayed expressive aggression in their sex offense(s).^d ◆ Juveniles who victimized peers or adults tended to use more force than those who victimized younger children.^k
Triggers	<ul style="list-style-type: none"> ◆ Some of the "triggers" that have been described as related to sex offending include anger, boredom, and family problems.^g

Notes: ^a Davis and Leitenberg, 1987; ^b Fehrenbach et al., 1986; ^c Hunter and Figueredo, 1999; ^d Miner, Siekert, and Ackland, 1997; ^e Rasmussen, 1999; ^f Righthand, Hennings, and Wigley, 1989; ^g Ryan et al., 1996; ^h Smith and Monastersky, 1986; ⁱ Wieckowski et al., 1998; ^j Knight and Prentky, 1993; ^k Becker, 1998.

found that among the juvenile sex offenders in their sample, there was a relationship between childhood experience of sexual abuse and higher rates of nonsexual reoffending but lower rates of sexual reoffending.

Not surprisingly, childhood experiences of being physically abused, being neglected, and witnessing family violence have been independently associated with sexual violence in juvenile offenders (Kobayashi et al., 1995; Ryan et al., 1996). Proportions of juvenile sex offenders who have experienced physical abuse as children reportedly range from 25 to 50 percent (Becker and Hunter, 1997). A study comparing juvenile sex offenders with juveniles who have committed nonsexual offenses suggests that sex offenders

may have higher rates of childhood physical abuse (Ford and Linsey, as cited in Becker and Hunter, 1997). When juvenile sex offenders were compared only with juveniles who have committed nonsexual violent offenses, however, this result was not replicated (Knight and Prentky, 1993). This latter finding suggests that a history of physical abuse is correlated with some type of violent behavior but not necessarily with sexually violent behavior.

The role of child maltreatment in the etiology of sex offending appears quite complex (Prentky et al., 2000). One recent study (Hunter and Figueredo, as cited in Becker and Hunter, 1997) used several comparison and control groups to investigate factors associated with sex offending, such as a history of

sexual victimization and family support. The study found four variables predictive of sex offending: younger age at the time of victimization, higher rates of abusive incidents, longer period between abuse and disclosure, and lower level of perceived family support following the disclosure of the abuse.

Cooper, Murphy, and Haynes (as cited in Becker, 1998) compared juvenile sex offenders who had been sexually or physically abused with those who had not. They found that the abused juveniles began their sex offending 1.6 years earlier than the nonabused group, had twice the number of victims, were more likely to have both female and male victims, and were less likely to limit their offending to family members.

Other research on various offender groups suggests that offenders with histories of maltreatment begin offending at earlier ages than other offenders who were not maltreated. For example, Knight and Prentky (1993) found that rapists who began offending as juveniles had higher rates of emotional neglect as children than other rapists who began their assaults in adulthood. Child molesters who began offending as juveniles also had higher rates of physical abuse as children than did child molesters who began offending in adulthood. Although these samples did not differ significantly regarding the experience of intrafamilial sex abuse, child molesters who began offending as juveniles had higher rates of sexual victimization experiences throughout their childhood than did rapists who began their offending as adults. Rapists who began offending while still juveniles, as contrasted with those who began offending in adulthood, tended to come from families where sexually deviant or abusive behavior was directed at other family members. Data pertaining to an additional group of sex offenders, who had no official record of juvenile sex offenses but who admitted to such behavior in a confidential, computer-generated interview, were similar. In this group, offenders who began perpetrating as juveniles, contrasted with those who began as adults, had overall higher rates of childhood sexual victimization, their sexually abusive experiences began at younger ages, and the sexual assaults they experienced as children tended to be more severe (i.e., on a scale ranging from fondling to intercourse).

Social and Interpersonal Skills and Relationships

Family Factors

In addition to child maltreatment, factors such as family instability, disorganization, and violence have been found to be prevalent among juveniles who engage in sexually abusive behavior (Bagley and Shewchuk-Dann, 1991; Miner, Siekert, and Ackland, 1997; Morenz and Becker, 1995). Studies vary as to the percentages of these juveniles who are from intact families. Some studies (Kahn and Chambers, 1991; Fehrenbach et al., 1986) have found that less than one-third of the juvenile sex offenders in their samples resided with both birth parents.

Graves et al. (as cited in Becker, 1998) used statistical procedures (meta-analysis) to analyze the findings of multiple studies that were conducted over 20 years and described characteristics of juvenile sex offenders. The analysis resulted in identification of three groups of juveniles: sexually assaultive juveniles, whose victims were the offenders' peers or older; pedophilic juveniles, whose victims were at least 3 years younger than the offenders; and a mixed group, described as including juveniles who perpetrated more than one class of sex offense, including hands-off and hands-on offenses (Weinrott, 1996). The Graves et al. results (as cited in Becker, 1998) also indicated that juveniles who committed sexual assaults against victims who were their peers or older were more likely to come from single-parent homes (78 percent) than those who committed "pedophilic" offenses (44 percent) or mixed offenses (37 percent). Those who committed pedophilic offenses, however, frequently lived with foster or blended families (53 percent).

Miner, Siekert, and Ackland's (1997) study of incarcerated offenders revealed that only 16 percent of the juveniles in their sample came from intact families. The low rate of intact families, however, may reflect the nature of the sample (i.e., incarcerated juveniles).

In contrast to these studies, Cellini (1995) reported that approximately 70 percent of juvenile sex offenders lived in two-parent homes at the time their

abusive behavior was discovered. It was not clear, however, whether the two parents in these homes were both birth parents.

Together, these various studies suggest that many juvenile sex offenders have experienced physical and/or emotional separations from one or both of their parents. The cause of this separation may be family instability, parental separation or divorce, or residential placement of the juvenile.

Research on family factors affecting juvenile sex offenders has also examined family communication styles and types of family involvement with the juvenile. Studies have found that supportive communication and comments that facilitate dialog are limited in the families of juvenile sex offenders and violent offenders, whereas negative communication, such as aggressive statements and interruptions, are frequent (Blaske, Borduin, Henggeler, and Mann, as cited in Morenz and Becker, 1995). Not surprisingly, adequate support and supervision may be lacking in the families of these juveniles (Borduin, Henggeler, Blaske, and Stein, as cited in Hunter and Figueredo, 1999).

In a comparison study of juvenile sex offenders and other juvenile offenders in two residential treatment centers, sexually assaultive juveniles were described as typically coming from intact, "hothouse" families that frequently evidenced severe pathology, including child maltreatment (Bagley and Shewchuk-Dann, 1991). Although the sexually aggressive juveniles experienced less family instability (as defined by multiple male adult caregivers and/or desertions by their father figure), their parents evidenced higher levels of marital stress. Furthermore, the mothers and fathers of these juveniles had more mental health problems that required intervention, and the fathers evidenced slightly greater rates of alcohol abuse. Parents of juveniles in the sexually aggressive group also were more likely to be overly ambitious for their children and excessively critical of poor school grades.

Similarly, Miner, Siekert, and Ackland (1997) described the juvenile sex offenders in their sample as coming from "chaotic" family environments. Nearly 60 percent of the biological fathers had substance abuse histories, and 28 percent had criminal

histories. Biological mothers, when compared to fathers, were less likely to have substance abuse histories (28 percent) or criminal histories (17 percent). The mothers, however, were more likely than the fathers to have a history of psychiatric treatment (23 percent versus 13 percent, respectively). Furthermore, nearly one-fifth of the subjects' siblings had criminal histories, and 29 percent of biological siblings and 20 percent of stepsiblings had psychiatric histories.

Smith and Israel (1987) found that some parents of juveniles who sexually abused their siblings were physically and/or emotionally inaccessible and distant. They also reported that some parents evidenced sexual pathology and exposed the juveniles to their sexual behaviors. Similarly, Miner and Crimmins (1995) found that sex-offending juveniles appeared to be more disengaged from their families than were other juveniles and, consequently, may have been cut off from possible sources of emotional support and less able to form positive attachments. This latter possibility gains some support from the finding of Kobayashi et al. (1995) that more positive relationships between juveniles and their mothers may be related to decreased levels of sexual aggression in juveniles. Weinrott (1996) reported there is strong evidence that family instability and problems in parent-child attachment in childhood are associated with more intrusive forms of juvenile sex offending.

Kimball and Guarino-Ghezzi (1996) found that the juveniles in their sample identified as child molesters reported significantly more ongoing conflict with a parental figure than was reported by juveniles identified as rapists. Rapists were significantly more likely than molesters to perceive their parents as not supportive of treatment. Stevenson and Wimberley (1990) opined, "The importance of family influences in the life of the adolescent sex offender cannot be underestimated as it is often the barometer of what can or cannot happen in treatment" (p. 59).

Social Skills and Relationships

Research repeatedly documents that juveniles with sexual behavior problems have significant deficits in social competence (Becker, 1990; Knight and Prentky, 1993). Inadequate social skills, poor peer relationships, and social isolation are some of the

difficulties identified in these juveniles (Fehrenbach et al., 1986; Katz, 1990; Miner and Crimmins, 1995). For example, Katz (1990) compared three groups — adolescent “child molesters,” juvenile delinquents who had not committed sex offenses, and a comparison group recruited from a local high school² — on various measures of social competence. The juveniles who had committed child molestation offenses were more socially maladjusted than either of the other groups and evidenced more social anxiety and fear of heterosexual interactions. Miner and Crimmins (1995) found that juveniles who have sexually offended had fewer peer attachments and felt less positive attachment to their schools, compared with other delinquent juveniles and nondelinquent juveniles. In fact, they stated that this and other research—

point to the primacy of isolation and poor social adjustment as distinguishing characteristics of adolescent sex offenders, indicating that interventions that maximize the ability to build interpersonal attachments potentially affect the propensity to engage in sexually abusive and aggressive behaviors. (pp. 9–11)

Sexual Knowledge and Experiences

Sexual Histories and Beliefs

Research suggests that adolescent sex offenders generally have had previous consenting sexual experiences (Becker, Kaplan, Cunningham-Rathner, and Kavoussi, as cited in Knight and Prentky, 1993; Groth and Longo, as cited in Knight and Prentky, 1993; Ryan et al., 1996). Research also suggests that sometimes their experiences have exceeded the experiences of control juveniles who have not committed sex offenses (McCord, McCord, and Venden, as cited in Knight and Prentky, 1993). Prior experiences with sexual dysfunction, most commonly impotence or premature ejaculation, have also been reported in juvenile sex offenders (Longo, as cited in Knight and Prentky, 1993). A study of 1,600

² Some of the high school students in the comparison group may have had contact with the juvenile or criminal justice systems, but this number was assumed to be small.

juvenile sex offenders described by 90 independent contributors from 30 States (Ryan et al., 1996) found that only about one-third of the juveniles perceived sex as a way to demonstrate love or caring for another person; others perceived sex as a way to feel power and control (23.5 percent), to dissipate anger (9.4 percent), or to hurt, degrade, or punish (8.4 percent).

Deviant Sexual Arousal

Studies of male college students and adult sex offenders have shown that deviant sexual arousal is strongly associated with sexually coercive behavior (Barbaree and Marshall, as cited in Hunter and Becker, 1994; Earls and Quinsey, as cited in Hunter and Becker, 1994; Prentky and Knight, as cited in Knight and Prentky, 1993). Controlled studies of deviant sexual arousal in juvenile sex offenders are lacking, although some related research has been reported.

In their sample of 197 juvenile sex offenders, Schram, Milloy, and Rowe (1991) found that sexual recidivists, defined as juveniles arrested for a new offense, were significantly more likely than other offenders to have deviant patterns of sexual arousal. Similarly, Kahn and Chambers (1991) found a trend associating deviant arousal and sexual reoffending, but it was not statistically significant. Both studies, however, relied on clinical judgments to determine the existence of deviant arousal, rather than more objective means such as phallometric assessment.

Knight and Prentky (1993) found that adult sex offenders who began offending as juveniles did not differ from those who began as adults in terms of preoccupation with sexual fantasies, problems with sexuality, or sexually deviant conduct. Knight and Prentky concluded this finding suggests that the importance of sexualization as an issue for juvenile sex offenders, as for adult sex offenders, may vary depending on the type of offender.

In their review of the role of deviant sexual arousal in juvenile sex offending, Hunter and Becker (1994) noted the limited research in this area and encouraged further investigations. They stressed that although deviant arousal may be more of a factor for sex offenders who target children (particularly those

who target boys), research suggests that juveniles who engage in sexually abusive behavior are a heterogeneous group. They also emphasized that the sexual interest and arousal patterns of these juveniles are more changeable than those of adult sex offenders and cautioned against applying to juveniles what is known about deviant arousal in adults.

Pornography

Investigations into the role of pornography in juvenile sex offending are limited in number. Becker and Stein (as cited in Hunter and Becker, 1994) found that only 11 percent of the juvenile sex offenders in their study reported that they did not use sexually explicit material. Approximately 74 percent reported that pornography increased their sexual arousal, 3 percent indicated it decreased their arousal, and 23 percent said it had no effect. There were no statistically significant differences between the subjects in terms of use of pornography and number of victims or in terms of types of pornography used and number of victims.

In a sample of 30 juveniles who had committed sex offenses, exposure to pornographic material at a young age was common (Wieckowski et al., 1998). The researchers reported that 29 of the 30 juveniles had been exposed to X-rated magazines or videos; the average age at exposure was about 7.5 years. Similarly, Ford and Linney (as cited in Becker and Hunter, 1997) found that 42 percent of juvenile sex offenders, compared with 29 percent of juvenile violent offenders (whose offenses were nonsexual) and status offenders, had been exposed to hardcore, sexually explicit magazines. The juvenile sex offenders also had been exposed at younger ages, ranging from 5 to 8. High rates of exposure to pornography also have been found for girls who have committed sex offenses (Mathews, Hunter, and Vuz, 1997).

Academic and Cognitive Functioning

Academic Performance

Studies typically report that, as a group, juveniles who sexually offended experienced academic difficulties (Fehrenbach et al., 1986; Kahn and

Chambers, 1991; Miner, Siekert, and Ackland, 1997; Pierce and Pierce, as cited in Bourke and Donohue, 1996). For example, Kahn and Chambers found that more than half of the juveniles in their study had evidenced at least one of three kinds of difficulty at school: disruptive behavior (53 percent), truancy (nearly 30 percent), or a learning disability (39 percent). Only 57 percent of the sample used by Fehrenbach et al. had achieved grade-appropriate placement or better. Pierce and Pierce found that 49 percent of the juvenile sex offenders in their sample had academic problems, 38 percent had been placed in special classes, and 14 percent were diagnosed as mentally retarded.

As part of an investigation of learning difficulties as a potential factor in sex offender treatment, Langevin, Marentette, and Rosati (1996) examined the case files of 162 male adult sex offenders who had participated in a treatment program and who had relevant data available. Fifty percent of the sample had repeated a grade. Although most of the subjects (43 percent) had repeated just one grade, 14 percent had repeated two grades and 3.5 percent had failed three or more grades. Seven others had been placed in special education classes as children. In all, 53 percent of the subjects apparently experienced learning difficulties during childhood.

Some juveniles who have sexually offended, however, do well in school. For example, O'Brien (as cited in Ferrara and McDonald, 1996) found that 32 percent of the offenders in his sample were described as above average in their academic performance.

Intellectual and Cognitive Impairments

Research that focuses on the intellectual and cognitive functioning of juveniles who have committed sex offenses is limited. Existing studies suggest that intellectual and cognitive impairments are factors that should be addressed (Awad, Saunders, and Levene, as cited in Knight and Prentky, 1993; McCurry et al., 1998). For example, in a comparative study of juvenile sex offenders and delinquents who had not committed sex offenses, the sex offenders had slightly lower IQ scores and more variability within subtests of standardized tests (Atcheson and Williams, as cited in Ferrara and McDonald, 1996).

In addition, more than one-quarter (25.2 percent) of the juvenile sex offenders had IQ scores below 80, whereas only 11.1 percent of the other delinquents scored in this range. Additionally, Saunders et al. (as cited in Ferrara and McDonald, 1996) found that violent juvenile sex offenders tended to have lower IQ scores than nonviolent sex offenders. Ferrara and McDonald argued that such differences may be attributed to higher rates of neurological impairments among violent offenders.

McCurry et al. (1998) noted that verbal deficits among juveniles who had conduct disorders and who scored within the average range on standardized tests were associated with higher rates of aggression and antisocial behavior. To investigate the role of verbal deficits in adolescents and children with inappropriate sexual behaviors, McCurry et al. studied 200 juveniles with serious psychiatric disorders, 99 of whom also evidenced inappropriate sexual behaviors such as hypersexuality (37 of the juveniles), exposing (24), and victimizing (38). Analyses revealed that, in general, subjects with lower IQ scores evidenced significantly more inappropriate sexual behaviors than did those with higher scores. This finding was especially true for subjects who molested or raped. Furthermore, subjects who evidenced the most serious inappropriate sexual behaviors had verbal IQ scores that were significantly lower than their performance IQ scores. The authors noted that deficits in verbal cognitive functioning, reflected by impulsivity and poor judgment, may contribute to the increased rates of serious inappropriate sexual behaviors among these juveniles. The authors stressed that treatment providers should consider the effects of verbal deficits when designing and applying interventions.

Lewis, Shanok, and Pincus (as cited in Ferrara and McDonald, 1996) investigated possible neurological deficits in a group of juvenile sex offenders and a comparison group of juveniles who had committed nonsexual but violently assaultive offenses. Psychological tests were administered,⁵ and sleep electroencephalographs (EEG's) were performed when possible. The groups did not differ on

⁵ Tests included the Wechsler Intellectual Scale for Children, Bender Gestalt, Woodcock Reading Mastery Tests, and Key Math Diagnostic Arithmetic Test.

full-scale, verbal, or performance IQ scores. Sex offenders evidenced greater difficulties on the reading test than the comparison group (5.59 versus 3.95 years below grade level, respectively). The results of the EEG's revealed the most direct evidence of neurological impairments among the juveniles from both groups: 23.5 percent of the sex offenders and 3.3 percent of the comparison group evidenced grossly abnormal EEG's or grand mal seizures. The finding of neurological impairments in both groups of juvenile offenders is consistent with other research regarding juvenile delinquents in general and violent juvenile offenders specifically (Ferrara and McDonald, 1996).

Academic functioning is not determined solely by intellectual or neurological functioning (parental level of education and support, truancy, and other variables are important); nevertheless, learning disorders are related to below-average academic achievement (Ferrara and McDonald, 1996). Furthermore, although the role of learning disabilities has not been well investigated, one study (O'Brien, as cited in Ferrara and McDonald, 1996) found that of a sample of 170 male adolescents who sexually offended, as many as 37 percent experienced learning disabilities.

The incidence of attention deficit disorders in juveniles with sexual behavior problems has not been satisfactorily examined. Kavoussi, Kaplan, and Becker (1988), however, found that of the 58 juveniles who had been evaluated or treated in an outpatient juvenile sex offender program, approximately 7 percent met the full diagnostic criteria for attention deficit disorder as specified in the *Diagnostic and Statistical Manual of Mental Health Disorders, 3rd Edition* (DSM-III). Nearly 35 percent of the juveniles evidenced some symptoms of an attention deficit disorder. Miner, Siekert, and Ackland (1997) found that more than 60 percent of the incarcerated juveniles in their study exhibited hyperactive and restless behaviors, and approximately 75 percent were identified as having attention problems, a learning disability, or both.

Although studies investigating specific areas of cognitive deficits in juvenile sex offenders are lacking, Ferrara and McDonald (1996) noted that research on juvenile delinquents has demonstrated two areas of impairment: difficulties with executive functions,

such as planning, abstraction, inhibition of inappropriate impulses, and cognitive flexibility; and difficulties with receptive and expressive language. Studies as noted above suggest that at least some juveniles who sexually offend do not differ significantly from juveniles who commit other types of offenses and that some juvenile sex offenders experience cognitive deficits similar to those identified in other groups of juvenile offenders. Based on their review of the literature, Ferrara and McDonald concluded that between one-quarter and one-third of juvenile sex offenders may have some form of neurological impairment. They noted, "Furthermore, it is likely that the neurologically impaired juvenile sex offender who goes undetected will not attain the [optimal] benefit from treatment due to problems in concentration, comprehension, and memory" (p. 13).

In their study of the impact of learning difficulties in adult sex offender treatment, Langevin, Marentette, and Rosati (1996) observed that cognitive and neuropsychological testing revealed that the average level of intellectual functioning of the sample was in the average range. A closer examination, based on normative data, revealed that more than expected fell within the borderline range of intellectual functioning (i.e., IQ of 70–79), fewer than expected were within the "bright normal" range (IQ of 110–119), and more than expected fell within the very superior range (i.e., IQ of 130–140). Neuropsychological testing with the Halstead-Reitan Battery indicated that 33 percent of the sample scored within the impaired range.

Cognitive Distortions and Attributions

Knight and Prentky (1993) pointed out that some factors observed in abused children may have relevance for juvenile sex offenders who have been maltreated. For example, they cited studies indicating that abused children evidence less empathy than nonabused children, have trouble recognizing appropriate emotions in others, and have difficulty taking another person's perspective. This observation is consistent with research indicating that cognitive distortions, such as blaming the victim, were associated with increased rates of sexual reoffending

among juveniles who committed sex offenses (Kahn and Chambers, 1991; Schram, Milloy, and Rowe, 1991).

Mental Health Issues

Symptoms and Disorders

Conduct disorder diagnoses and antisocial behavior frequently have been observed in populations of juveniles who have sexually offended (Kavoussi, Kaplan, and Becker, 1988; Miner, Siekert, and Ackland, 1997). For example, Kavoussi, Kaplan, and Becker found that the most common DSM-III diagnosis in their sample of male juvenile sex offenders was a conduct disorder (48 percent). Most of the juveniles were classified with the socialized, non-aggressive type. A much higher rate of conduct disorders was found among juveniles who had raped or attempted to rape adult women (75 percent).

In addition to conduct disorder diagnoses and antisocial traits, studies have described other behavioral and personality characteristics in juveniles who have sexually offended. For example, impulse control problems and lifestyle impulsivity have been associated with juvenile sex offending (Prentky and Knight, as cited in Prentky et al., 2000; Smith, Monastersky, and Deisher, as cited in Prentky et al., 2000). Carpenter, Peed, and Eastman (1995) found that adolescents who sexually offended against younger children evidenced higher scores on the Schizoid, Avoidant, and Dependent scales of the Millon Clinical Multiaxial Inventory (MCMI) than those who offended against age peers. These differences were statistically significant. Carpenter and colleagues also found that the degree of narcissism in the group of adolescents who offended against peers was within the clinically significant range, whereas the degree of narcissism in the group who offended against younger children was not clinically significant. The difference between the scores of the two groups on the narcissism scale was not, however, statistically significant. In another study, Schram, Milloy, and Rowe (1991) described slightly more than half of the juveniles in their sample of juvenile sex offenders as shy or immature.

Studies have indicated that juveniles who have sexually offended have higher rates of depressive symptoms than are found in the general juvenile population (Becker, Kaplan, and Tenke, as cited in Becker and Hunter, 1997; Kaplan, Hong, and Weinhold, as cited in Becker and Hunter, 1997). Sexually aggressive juveniles who had histories of childhood physical abuse or sexual abuse had higher rates of depressive symptoms, with as many as 29.2 percent of these offenders appearing severely depressed (Becker, as cited in Becker and Hunter, 1997). Becker and Hunter stressed that this finding illustrates the importance of evaluating whether juvenile sex offenders are experiencing symptoms of depression, especially if they have been victimized themselves.

Few studies of adolescents and children who evidence sexual behavior problems report major psychopathology in the subjects or their families (Becker, as cited in Ferrara and McDonald, 1996; Johnson, as cited in Ferrara and McDonald, 1996). Sexually aggressive juveniles placed in residential programs, however, evidence higher levels of "emotional disturbance," compared with other juveniles in these programs (Lewis et al., as cited in Ferrara and McDonald, 1996). Bagley and Schewchuk-Dann (1991) studied male juveniles in two residential treatment centers. They found that residents with sexual behavior problems, as compared with an age-matched control group of residents with no record of sexual problems, demonstrated higher levels of hyperactivity or restlessness; more depression and anxiety; more histories of fire setting, encopresis (defecation in inappropriate places), and running away; more early-onset neurological conditions or illnesses; more learning disorders; and health problems beginning at an earlier age. In contrast, juveniles from the control group were more aggressive toward peers and siblings and were more destructive of possessions and property.

Substance Abuse

Studies vary widely on the importance of substance abuse as a factor in sex offending among juveniles. Lightfoot and Barbaree (1993) reported that rates at which juvenile sex offenders were found to be under the influence of drugs or alcohol at the time they committed their offenses ranged from 3.4 to 72 percent.

Although substance abuse has been identified as a problem for many juveniles who have sexually offended (Kahn and Chambers, 1991; Miner, Siekert, and Ackland, 1997), the role of substance abuse in sex offending remains unclear, and for some juveniles, substance abuse may not be related to sex offending. Becker and Stein (as cited in Hunter and Becker, 1994) found that although 62 percent of the juvenile sex offenders in their study admitted to alcohol use, only 11 percent reported that alcohol use increased their sexual arousal. Statistical analyses indicated that the juveniles who reported increased arousal had more victims than those who said alcohol had no effect on their arousal or who said they did not drink. Illicit drug use was less commonly reported than alcohol use among these juveniles: 39 percent reported illicit drug use. Of these, approximately 23 percent reported that it increased their sexual arousal. There were no statistically significant differences between subjects in terms of drug use and number of victims.

As Lightfoot and Barbaree (1993) pointed out, assessments should differentiate substance abuse problems from "normative" experimentation that is part of the developmental process. They noted that classification schemes have been developed (George and Skinner, as cited in Lightfoot and Barbaree, 1993) to differentiate between infrequent, experimental, recreational, and chronic users and between different types of life problems associated with substance abuse among juvenile offenders (Lightfoot, Lightfoot, and Hodgins, as cited in Lightfoot and Barbaree, 1993). These authors stressed the importance of adequate assessments of substance abuse as part of a comprehensive evaluation of sex offenders. They pointed out that offenders who have evidence of organic impairment, possibly as a result of their substance abuse, are likely to require treatment similar to that required by offenders who are below average in intellectual functioning. Such treatment approaches should be simple and concrete, provide opportunities to rehearse new skills, and include strategies to facilitate the development and use of new skills in a variety of settings. The authors also noted that even among adolescents who are infrequent substance abusers, issues such as poor impulse control, problem-solving difficulties, and poor social skills can be exacerbated by even small amounts of

substance and, consequently, may increase the risk of sex offending. Lightfoot and Barbaree (1993) further suggested that whereas less frequent users may benefit from substance abuse treatment efforts that are part of a comprehensive treatment program, more chronic users may require more intensive substance abuse treatment efforts, possibly prior to treatment related to sex offending.

It appears that evidence is insufficient to identify substance abuse as a causative factor in the development of sexually abusive behavior, although substance abuse has a disinhibiting potential and, if present, may require intervention. For example, Miner and Crimmins (1995) found that the

substance abuse histories of juvenile sex offenders were very similar to those of other adolescents, including both nonoffenders and juveniles who committed violent but nonsexual offenses. Although the three groups did not differ in their alcohol abuse, the violent nonsexual offenders had the highest rates of drug abuse. Yet, as Lightfoot and Barbaree (1993) have suggested, assessments of juveniles who have committed sex offenses would do better to determine not simply whether substance abuse is present in a juvenile's life but whether it is a risk factor for offending. If it is found to be a risk factor, the next step is to evaluate what interventions are required to reduce this risk.

Types and Classifications

Types and Classifications of Male Adolescents Who Have Committed Sex Offenses

Although a variety of characteristics have been identified among juveniles who have sexually offended, few studies have attempted to classify these juveniles according to their similarities and differences.

Weinrott (1996) noted that even though it is widely accepted that juveniles who have abused young children differ from those who have sexually assaulted peers, most studies of juvenile sex offenders combine these groups. Furthermore, in spite of alarming statistics pertaining to the prevalence of juvenile sex offending, sexual recidivism rates for juvenile sex offenders typically are very low (Weinrott, 1996). The apparently low recidivism rate suggests that there may be a significant subgroup of identified juvenile sex offenders who do not continue to commit sex offenses as adults (Knight and Prentky, 1993). Such a finding would be consistent with the literature on juvenile delinquents (Tolan and Gorman-Smith, 1998). Yet, studies investigating this probability are lacking. Research on juveniles who commit sex offenses that differentiates these juveniles according to their various behavior patterns, cognitive and emotional functioning, and other relevant factors is needed to determine and apply appropriate and effective treatment strategies.

Becker and Kaplan (as cited in Becker, 1998) proposed that an initial sex offense by a juvenile results from a combination of individual factors such as a lack of social skills, family factors such as familial relationships, and social-environmental factors such as social isolation. They suggested that three paths are possible after the initial offense: a dead end (no further crimes), a delinquency path, and a sex

interest path involving continued sex offending and, frequently, the development of deviant sexual arousal patterns. Becker (1998) pointed out that this hypothesized model, like other classification models, has not been empirically validated.

In 1986, O'Brien and Bera (as cited in Weinrott, 1996) grouped juvenile sex offenders into the following seven categories:

- ◆ Naive experimenters.
- ◆ Undersocialized child exploiters.
- ◆ Sexual aggressives.
- ◆ Sexual compulsives.
- ◆ Disturbed impulsives.
- ◆ Group influenced.
- ◆ Pseudosocialized.

Although this classification scheme has been described as having much "face validity" (Weinrott, 1996) and has been recommended to facilitate interventions and treatment (e.g., Avalon Associates, 1986), systematic investigations of its reliability and validity are lacking. Some indirect support for the O'Brien and Bera (as cited in Weinrott, 1996) classification scheme comes through the work of Knight and Prentky (1993). These researchers reported that four of the O'Brien and Bera types overlap with factors supported by the empirical literature and by their own research with adult offenders who committed sex offenses as juveniles.

Knight and Prentky (1993) compared adult sex offenders who had official records of juvenile sex offending with those who did not. They also compared

a third group of “hidden juvenile sex offenders” — individuals who reported they had committed sex offenses as juveniles but who did not have official records of such offenses. Their findings indicated that certain factors, such as low social competence and high rates of antisocial behavior and impulsivity, differentiated sex offenders who began offending as juveniles from those who did not. These factors also are significant in differentiating types of adult sex offenders. For example, of the nine rapist types, three — low social competence/opportunistic, low social competence/nonsadistic/sexual, and low social competence/vindictive — have low social competence as a defining characteristic. Combined, these findings suggest that the sex offender classification schemes validated by Knight and Prentky (1993) for adults may also be useful for differentiating juvenile sex offenders. The authors noted that social competence also is an important factor in the child molester typology, along with factors such as degree of sexual pre-occupation and amount of contact with children.

Graves (as cited in Weinrott, 1996) conducted a meta-analysis of 140 samples involving 16,000 juvenile sex offenders. Results suggested three typologies: pedophilic, sexual assault, and undifferentiated. Pedophilic juveniles tended to lack social confidence and to be socially isolated, consistently molested much younger children (at least 3 years younger than themselves), and typically molested girls. The sexual assault group typically assaulted peers or older females. The undifferentiated group committed a variety of offenses, and the ages of their victims varied widely. This latter group engaged in hands-off offenses (e.g., exhibitionism) in addition to hands-on assaults. Compared with the other two groups, they began their abusive behavior when they were younger, had the most severe social and psychological problems, were more antisocial, and had more dysfunctional families.

Prentky et al. (2000) employed a rationally derived classification system to describe their sample of male juvenile sex offenders. They used the following six categories: child molesters (69 percent of the sample), rapists (12.5 percent), sexually reactive children (6.25 percent), fondlers (3 percent), paraphilic offenders (3 percent), and unclassifiable (6.25 percent). In the child molester category, all victims were under age 12 and offenders were at

least 5 years older than victims. In the rapist category, all victims were age 12 or older and the age difference between offenders and their youngest victims was less than 5 years. Sexually reactive children were under age 11, as were their victims. In the fondler category (as in the rapist category), all victims were age 12 or older and the age difference between offenders and their youngest victims was less than 5 years; sexual acts in this category were limited to fondling, caressing, or frottage (i.e., touching or rubbing against a nonconsenting person for sexual arousal). Paraphilic offenders had no physical contact with their victims; acts included, for example, exhibitionism and obscene phone calls. Prentky et al. (2000) reported that these categories also were used by Becker and Kaplan, who found similar proportions of offenders in each category (with the exception of a somewhat higher proportion of rapists).

Weinrott (1998a) suggested four general types of juveniles who have sexually abused others. Three of these types are those who are juvenile delinquents in general, those who have deviant arousal, and those who are psychopathic offenders. The other type includes juveniles who fit none of these categories and may only require limited interventions, such as those that establish appropriate rules for future sexual behavior.

Malamuth’s research with college students (as cited in Miner and Crimmins, 1995) suggested that sexual aggression resulted from the interaction of two pathways: hostile masculinity and sexual promiscuity. Hostile masculinity involves beliefs that to be male involves taking risks; being powerful, tough, dominant, competitive, and aggressive; and defending one’s honor. The sexual promiscuity pathway reflects age at first intercourse and number of sexual partners since the age of 14. High scores on both pathways were associated with high rates of sexual aggression against women.

Sibling Incest

Few reports have specifically addressed issues pertaining to sibling incest. Araji (1997) noted that although sibling incest appears to be quite prevalent, often it is underreported and ignored. Various

factors probably contribute to this apparent tendency to minimize the incidence of sibling abuse. For example, in contrast to extrafamilial sexual abuse, parents may be especially reluctant to report to authorities that one of their children has sexually abused another child in their home.

O'Brien (1991) emphasized the importance of "Taking Sibling Incest Seriously" with the title of his paper. He compared 170 juveniles who sexually offended against siblings (including stepsiblings, half siblings, and adoptive siblings) with extrafamilial offenders (those who offended against children other than their siblings), those who sexually victimized peers or adults, and those whose victims may have included a mix of sibling and extrafamilial children and/or peers and adults.⁴ As a group, sibling offenders perpetrated the greatest number of abusive acts (an average of 18 incidents, compared with 4.2 for extrafamilial offenders, 7.4 for peer/adult offenders, and 8.5 for the mixed group). The duration of sex offending was greatest for sibling offenders. Nearly 45 percent of the sibling offenders had been committing offenses for more than a year, whereas only 23 percent of the extrafamilial offenders and 24 percent of the adult/peer offenders had been offending for this long. In addition, the sibling offenders were more likely than the others to vaginally or anally penetrate their victims (46 percent, compared with 28 percent of the extrafamilial offenders and 13 percent of the adult/peer offenders). Sibling offenders also were more likely to have multiple victims. O'Brien hypothesized that specific issues, such as victim availability, the nature of the sibling relationship, and other factors, may have contributed to such serious offending histories. In spite of such abusive behaviors, only about one-third of the sibling offenders had court-ordered treatment, compared with three-quarters of the other offenders.

Family factors such as an increased rate of physical abuse were noted among the sibling offenders (61

⁴ Information about the number of abusive acts was provided for all groups. Information about the duration of offending and other reported variables was provided for sibling, extrafamilial, and peer/adult offenders but not for the mixed group.

percent, compared with 45 percent of the extrafamilial offenders and 37 percent of the adult/peer offenders). Sibling offenders also were sexually abused more frequently by their fathers than were other offenders, although only a small number of the sibling offenders had been sexually abused by any family member (including fathers). Interestingly, 36 percent of the sibling offenders' mothers and 10 percent of their fathers had been victims of sexual abuse as children, compared with 9.1 percent of the extrafamilial offenders' mothers and 5.5 percent of their fathers. Assessments also suggested that the rate of family dysfunction was higher for sibling offenders than for the other groups.

An early study of inner-city minority juveniles from low socioeconomic backgrounds (Becker et al., 1986) questioned the existing assumption that sibling offenders are significantly different from other juvenile sex offenders. Becker et al. noted that 9 of the 22 adolescents in their small sample also had evidenced nonsibling paraphilic behaviors. In view of the O'Brien (1991) study that found significant group differences between sibling and nonsibling sex offenders, it may be that, as in any group of sex offenders, juveniles who perpetrate sibling abuse are a heterogeneous mix. In fact, Becker and her colleagues noted that the juveniles in their sample included adolescents who engaged in consensual sexual behavior with a peer-aged relative, those whose sexual activity with a peer-aged relative began as consensual but became coercive when the relative withdrew consent, those who had developed deviant sexual interests, and those who engaged in both nondeviant and deviant sexual behavior.

In their discussion of sibling abuse, Bonner and Chaffin (1998) asserted that most interventions designed to address sibling sexual behavior assume a victim-perpetrator model. They noted that such a model may be appropriate when the sexual behavior has been abusive but cautioned that it is progressively less appropriate (and may be damaging) when sibling cases involve inappropriate mutual sexual behavior or, especially, age-appropriate sex play.

Girls Who Have Committed Sex Offenses

Incidence

Before 1986, references in the professional literature to female sex offenders were few and limited. Since then, some references have appeared, but research studies continue to be few, and studies of adolescent girls are relatively rare. Existing studies often are limited by small sample sizes and retrospective analysis of selected populations that may not be representative of the general population.

Lane and Lobanov-Rostovsky (1997) reviewed the literature on young sex offenders and found that adolescent female sex offenders represented between 2 and 3 percent of juveniles involved in two different treatment programs. These authors also cited the results of several statewide incidence studies conducted in the 1980's. The studies revealed that females represented 5 percent (19) of the juveniles arrested for sex offenses in Oregon in 1985, 8 percent (12) of the children identified as adolescent sex offenders by the Vermont Social Rehabilitation Services Department or Corrections Department in 1984, and 7 percent of the juveniles referred to juvenile court in Utah over a 5-year period. In a Maine study (Righthand, Hennings, and Wigley, 1989), females represented 11 percent (40) of the 348 juveniles identified as sex offenders by the Maine Departments of Human Services and Corrections during a 12-month period between 1988 and 1989.

In a more recent study by the Washington State Department of Social and Health Services, English and Ray (as cited in Araj, 1997) found that of 200 juveniles identified as sexually aggressive, 9.3 percent of those age 13 or older were female, compared with 19.1 percent of those age 12 and under. This relatively high rate of sex offending by young girls also was found by Johnson (as cited in Lane and Lobanov-Rostovsky, 1997). Girls who had been sexually abusive made up 21.6 percent of the children in her program for children ages 4 to 12 who had engaged in inappropriate sexual behavior. Gray et al. (1997) also found a relatively high rate of pre-adolescent girls who evidenced sexual behavior

problems. In their sample, 35 percent of the children who evidenced such problems were girls.

Incidence reports on juvenile sex offenses may underestimate the extent of the problem for female offenders even more than for male offenders. Underestimates may occur because there is a general tendency to underreport sex crimes committed by females (Charles and McDonald, 1997). It has been hypothesized that this underreporting might result from a societal reluctance to acknowledge that girls are capable of committing criminal offenses, particularly sex offenses; even professionals may be reluctant to report female disclosure of sex offenses (Travin, Cullen, and Protter, 1990).

Characteristics of Female Offenders and Their Offenses

Ray and English (1995) compared girls and boys who were described as sexually aggressive and who were actively involved with their State's public social service agency. Findings indicated that the girls tended to be younger than the boys and were less likely to have perpetrated acts of rape. (Rape was defined as involving force or no consent and vaginal, oral, or anal penetration with a penis or object.) Approximately 94 percent of the girls in the sample had been victims of sexual abuse, compared with 85 percent of the boys. A greater percentage of girls than boys (94 percent versus 86 percent) had experienced multiple types of abuse, including sexual abuse, physical abuse, emotional abuse, and/or neglect.

All of the children in the Ray and English sample (1995) evidenced a wide range of behavior problems while under the State agency's supervision. Girls were significantly more likely than boys to steal and display temper tantrums. There also was evidence that girls were more likely to be truant. Girls appeared to have more adequate social skills and more empathy toward their victims, whereas boys tended to be more coercive and sophisticated in their sex offending. Use of sexual aggression appeared to be escalating more in boys than in girls. Another noteworthy difference was that although approximately one-third of all the juveniles studied were legally charged with an offense, only 2 girls (as contrasted

with 93 boys) were charged. The study also found that girls were significantly more likely than boys to receive assessment and treatment for their experiences of being abused.

Fehrenbach and Monastersky (as cited in Bumby and Bumby, 1997) found that, in their sample, most adolescent girls who sexually victimized children age 12 or younger frequently did so while engaged in a childcare situation. In their sample, 53.6 percent of the adolescent girls committed some form of penetration (oral, anal, or vaginal intercourse or other forms of penetration); 46.4 percent engaged in fondling.

Hunter et al. (as cited in Bumby and Bumby, 1997) conducted a descriptive study of 10 girls who had sexually offended and who were in a residential care program for juveniles with emotional and behavioral problems. The study, although limited by the small sample size and lack of a comparison group, is informative. The girls had high rates of previous mental health services (80 percent). Many had a history of suicide attempts or ideation (60 percent), running away (60 percent), substance abuse (40 percent), enuresis (bed wetting, 40 percent), and/or learning disabilities (40 percent).

All of the girls reported a history of sexual victimization experiences, including the following:

- ◆ All had been sexually abused by more than one offender; the number of offenders ranged from two to seven.
- ◆ Experience of victimization began at early ages, ranging from 1 to 8 years; the median age was 4.5 years.
- ◆ All of the girls reported being sexually abused by a male; 60 percent also reported being abused by a female.
- ◆ Ninety percent of the girls reported actual or attempted vaginal penetration, 60 percent reported actual or attempted anal penetration, 70 percent reported having oral sex performed on them, and all reported being fondled.
- ◆ Ninety percent reported that force was used in their sexual victimization experiences, yet 80 percent reported that they experienced some sexual

arousal during at least one of their experiences as a victim.

In regard to their sex-offending behavior, these girls reported the following:

- ◆ They typically victimized younger children; victim ages ranged from 1 to 13 years, with a median age of 5.5 years.
- ◆ Their victims most frequently were strangers (39.4 percent); other victims were siblings (30.3 percent), other relatives (18.2 percent), and acquaintances (12.1 percent).
- ◆ They had fantasies about the deviant sexual behavior (in 89 percent of the cases).
- ◆ Their sexually offensive behavior included vaginal intercourse (70 percent), anal intercourse (10 percent), oral sex (70 percent), and fondling (100 percent).

Most of the girls in this sample also engaged in non-sexual delinquent behaviors such as stealing and physical aggression. Most had not been formally charged for these behaviors.

The findings of the above studies are fairly consistent with Bumby and Bumby's (1997) findings from their sample of 12 adolescent female offenders who were inpatients at a psychiatric facility for children and adolescents with emotional and behavioral disorders. Again, the girls in this sample tended to select young victims. Most often their victims were family members (75 percent). In contrast to the sample studied by Hunter et al. (as cited in Bumby and Bumby, 1997), none of these girls victimized strangers. Eleven of the twelve girls perpetrated their offenses when providing childcare.

A review of the characteristics of the girls in the Bumby and Bumby (1997) sample indicated that most (83 percent) experienced academic difficulties, although all but three fell within the average intellectual range; all but one had peer difficulties at school; and two-thirds had been suspended or expelled for physical aggression toward peers or teachers or for other causes. Behavior problems were common: 75 percent had abused alcohol, 58 percent had abused drugs, 58 percent had run away from

home, 58 percent had been truant from school, and 33 percent had been arrested for stealing. Psychiatric diagnoses included conduct disorders, oppositional-defiant disorder, major depression, posttraumatic stress disorder, adjustment disorder, and chemical dependency. Most (83 percent) had received previous mental health services, 33 percent had histories of self-mutilation, and 58 percent had attempted suicide. Anger control problems were described as common (67 percent), as were low self-concepts (100 percent). Peer relations were very strained; 75 percent of the girls were described as significantly socially isolated, which possibly was related to their high rate of aggressive behavior toward peers (67 percent). A significant number (58 percent) were described as sexually promiscuous, having had many sexual relationships with older males. All of these girls had been sexually victimized themselves. They tended to have been sexually abused by more than one person. Seventy-five percent had been physically abused, and 42 percent had experienced emotional or physical neglect. In general, their families were described as dysfunctional and chaotic.

To provide additional information about their adolescent sample, Bumby and Bumby (1997) compared 18 female sex offenders to a group of female nonoffenders, male sex offenders, and male nonoffenders of similar age. All juveniles were inpatients at a psychiatric facility for children and adolescents with emotional and behavioral disorders. Psychological test results suggested that the adolescent female sex offenders experienced a number of psychological symptoms and difficulties. They had higher scores than the female nonoffenders on the psychopathic deviate, paranoia, and psychasthenia scales of the Minnesota Multiphasic Personality Index-Adolescent (MMPI-A). They did not, however, differ significantly from the male sex offenders and male nonoffenders.

The female sex offenders evidenced significantly more symptoms of anxiety and depression (including suicidal thoughts and behaviors) than the female nonoffenders but did not differ from the male sex offenders in this regard. The female sex offenders had higher rates of academic failure (having been

retained for one grade in school) and truancy than the male sex offenders but did not differ from the female or male nonoffenders on these measures. Although delinquent behaviors, socially inappropriate behaviors, and status offenses were frequent among female sex offenders, the frequency did not differ significantly from that found in the other groups, with the exception that female sex offenders had higher rates of drug abuse and sexual promiscuity than the male sex offenders. In addition, although high rates of childhood sexual victimization occurred across all groups, the female sex offenders experienced significantly more sexual abuse than the other groups.

Again, these findings are informative but are limited by the small sample size. The authors point out, however, that their findings are consistent with the limited available information. The authors suggest that factors such as depression, suicidal ideation, anxiety, poor self-concept, and childhood sexual victimization are targets for assessment, and possibly treatment, in girls who commit sex offenses.

In perhaps the largest study to date, Mathews, Hunter, and Vuz (1997) compared 67 girls who were referred to community-based treatment or residential treatment subsequent to histories of sex offending with 70 boys who also had such histories. Because the samples did not meet scientific standards of comparability, statistical tests of differences between groups could not be used. A review of the findings, however, suggested some meaningful similarities and differences between the girls and the boys. The girls' offending behaviors were similar to the boys' in terms of offense types and style of victim selection. For example, both girls and boys committed the following types of offenses: fondling (77.6 percent girls, 75.4 percent boys), oral sex (47.8 percent girls, 29.7 percent boys), and vaginal or anal intercourse (26.9 percent girls, 54.5 percent boys). Also like the boys, the girls tended to victimize young children of the opposite gender. In contrast to the boys, and consistent with other studies, the girls typically had more severe victimization experiences themselves.

These abusive experiences were characterized by a higher average number of perpetrators, younger age at the time of first victimization, and greater likelihood of having been a focus of their perpetrator's aggression. Girls also were three times more likely than boys to have been victimized by female perpetrators. Like boys, however, the girls' victimization by a perpetrator of the same gender seemed related to the girls' having sexual identity problems.

Other findings in Mathews, Hunter, and Vuz (1997) indicated that in addition to experiencing high rates of abuse and trauma, the girls in this study typically came from families evidencing high levels of dysfunction and an absence of parental support. Their family environments usually appeared detrimental for the development of healthy attachments and a positive sense of self. Although a small subgroup of the girls evidenced little psychopathology and limited offending behaviors, about one-third of the outpatient girls in the study evidenced mild to moderate levels of psychopathology, and about half of the entire sample appeared to have moderate to severe psychopathology. Problems included behaviors associated with conduct disorders, impulsivity, substance abuse, suicidal behaviors, and unprotected sex. A subgroup of the girls also evidenced deviant sexual arousal patterns, posttraumatic stress disorder, depression, and anxiety. In sum, the authors concluded:

Overall, the data from this study seem consistent with the authors' impression that biological and socialization factors create a higher threshold for the externalization of experienced developmental trauma in females than males. In this regard, it may be that females are generally less likely than males to manifest the effects of maltreatment in the form of interpersonal aggression or violence and that females who develop such patterns of behavior are generally those who have experienced remarkably high levels of such developmental trauma in the absence of environmental support for recovery and the presence of healthy female role models. (p. 194)

Young Children Who Have Committed Sex Offenses

Incidence

In the 1980's, after the problem of adolescent sex offending gained attention, similar behaviors in pre-adolescent and younger children also were recognized. Knopp (as cited in Araj, 1997) observed that the 1980 Uniform Crime Reports identified 208 children under the age of 12 who were arrested for rape. Thirty-seven of these children were age 10 or younger. Knopp found somewhat higher rates for 1979: in that year, 249 children under the age of 12 were arrested for rape; 66 of these children were age 10 or younger. The Uniform Crime Reports stopped reporting age ranges in 1980 (Araj, 1997).

Recent surveys of children with sexual behavior problems (including nonadjudicated children) reveal substantially higher rates of sexually abusive behavior by preadolescent children than the rates cited in the Uniform Crime Reports. For example, English and Ray (as cited in Araj, 1997) reported that the Washington Department of Social and Health Services had 641 active cases of children under age 12 who had raped, molested, or engaged in noncontact sexual acts such as exposing, masturbating in public, or peeping. Gray and Pithers' Vermont studies (as cited in Araj, 1997) identified 200 children under age 10 who had sexually abused others between 1984 and 1989; even more striking, they identified 100 children who had sexually abused others in a single year, 1991. In addition, in a sample of 616 juveniles who had been referred for evaluation or treatment after the age of 12 for committing a sex offense, 25.9 percent had been sexually abusive prior to their 12th birthday (Ryan et al., 1996). This apparent increase in the rate of preadolescent children who evidence sexually abusive behaviors probably reflects a greater awareness of the problem.

In an extensive review of the published and unpublished literature pertaining to children who have been sexually aggressive, Araj (1997) stressed that research in this area is in its infancy and noted that many findings are simply clinical observations. Araj's point has relevance for the findings presented in this Report: because this area of research is so

new, the findings presented must be considered preliminary and interpreted with caution.

Individual Characteristics

With this caution in mind, available studies (Araji, 1997) have reported that preadolescent children who have been sexually aggressive include children as young as 3 and 4, although the most common age of onset appears to be between 6 and 9. Contrary to findings regarding adolescent children who have committed sex offenses, girls were represented in much greater numbers among preadolescents who have sexually abused. Furthermore, these girls had often engaged in behaviors that were just as aggressive as the boys' actions. The number of reported victims for these preadolescent children ranged from one to nine; many had multiple victims. Victims tended to be quite vulnerable. They generally were young (averaging between ages 4 and 7); typically were siblings, friends, or acquaintances; and most often were female.

Studies generally have found high rates of sexual victimization histories among preadolescent children who have sexually abused: 50–75 percent of the boys and 100 percent of the girls in studies that provided this information by gender (Johnson, as cited in Araji, 1997; Friedrich and Luecke, as cited in Araji, 1997; Araji, Jache, Tyrrell, and Field, as cited in Araji, 1997; Araji, Jache, Pfeiffer, and Smith, as cited in Araji, 1997; Bonner, Walker, and Berliner, as cited in Araji, 1997; Pithers et al., 1998b). English and Ray (as cited in Araji, 1997) found that preadolescent children who have sexually abused have significantly higher rates of abuse and neglect victimization experiences than their adolescent counterparts. Furthermore, Friedrich and Luecke (as cited in Araji, 1997) also found severe sexual victimization experiences among sexually aggressive children when contrasted with two samples of children who were not sexually aggressive (one with a history of sexual victimization and one without). The children who were sexually aggressive experienced more severe types of sexual abuse that generally involved genital contact and penetration. Research by Friedrich and Luecke (as cited in Araji, 1997) and Pithers and Gray (as cited in Araji, 1997) also suggests that the children who engaged in sexually aggressive behaviors frequently experienced

academic and learning difficulties and impaired peer relationships.

Family Characteristics

Studies described by Araji (1997) also suggest that the families of children who engaged in sexually aggressive behavior tended to be characterized as dysfunctional, evidencing high rates of parental separation, domestic violence, substance abuse, highly sexualized environments (e.g., exposing children to sexual activity, pornography, and both covert and overt sexual abuse), unsatisfactory role models, poor parent-child relationships, parental histories of childhood abuse, and so on. After reviewing the available research, Araji concluded, "The evidence . . . points to family interactions as a primary source of the problem" (p. 87).

The importance of family factors is supported by research conducted by Pithers et al. (1998a) concerning the caregivers of children with sexual behavior problems. These researchers used a structured interview and standardized measures to investigate the characteristics of these caregivers. Findings indicated that the caregivers and their families experienced much stress. Of the 72 children in the study (75 percent of whom resided with biological parents and 25 percent with foster parents), 38 percent resided in families whose income fell below the Federal poverty level (defined as a family of four or more with an annual income of less than \$15,000). Comparisons between biological families and foster families revealed that 72 percent of the biological families and 28 percent of the foster families had incomes below the poverty level. Families also had a high rate of single parenting: approximately half of the parents (51.4 percent) were living with a partner.

The family environments of these children, particularly their biological families, were characterized as disorganized and as requiring much effort to meet the basic needs of the family. The families had a high rate of sexual abuse histories. Most families (72 percent) included at least one sexual abuse victim (other than the child being studied), and more than half of the extended families (62 percent) included at least one person (other than the child being studied) who had perpetrated sexual abuse. Sexual

abuse victims of the children studied typically were relatives (94 percent). Very few of these children assumed responsibility for their sexually abusive behaviors (10.3 percent).

More than half of the children studied had witnessed domestic violence in the families with whom they were currently residing. Most witnessed violence between their biological parents (70.2 percent). Some observed partner violence in their foster homes (20 percent). In general, foster families seemed to provide more functional environments, experienced less conflict, and were more cohesive.

The individual functioning of the female caregivers⁵ was measured with the Brief Symptom Inventory (Derogatis, as cited in Pithers et al., 1998a; Derogatis and Spencer, as cited in Pithers et al., 1998a). The results suggested that, as a group, these women were significantly more psychologically distressed than most people in the general population. The biological parents evidenced significantly more distress than the foster parents. Parenting stress among female caregivers was measured by the Parenting Stress Inventory (Abidin, as cited in Pithers et al., 1998a). Both biological and foster parents appeared to experience significant parenting stress that warranted referrals for professional care. Again, the biological parents evidenced significantly more stress than the foster parents. Both groups cited their children as a major source of their parenting stress, and both groups evidenced impaired attachments to their children. In spite of these findings, parents typically denied having problems associated with parenting and appeared defensive about some personal difficulties.

Comparative Studies of Preadolescents and Adolescents Who Have Committed Sex Offenses

In one of the few existing comparative studies involving children who committed sex offenses, English and Ray (as cited in Araj, 1997) studied 271 juveniles who sexually offended by comparing

the preadolescents (32.8 percent) with the adolescents (67.2 percent). Although the researchers found many similarities between the groups (e.g., previous aggressive behavior, psychiatric problems, and levels of intellectual functioning), the adolescents evidenced significantly higher rates of aggression and coercion and greater sophistication in committing their sex offenses. The older juveniles also were less empathic, were more likely to minimize the seriousness of their abusive behavior, and evidenced more escalating sexual violence. The adolescents also had higher rates of depressive symptoms and suicidal gestures. As Araj suggested, this latter difference may reflect developmental differences between the groups, as the older juveniles may have begun to internalize their difficulties in addition to expressing them outwardly.

English and Ray (as cited in Araj, 1997) also found that both groups had a moderate to moderately high number of risk factors that were considered by the authors to be associated with repeat offending. (The authors evaluated 32 risk factors in 3 categories: family and environment, juvenile characteristics, and victim characteristics.) The preadolescent children's families, however, evidenced significantly more family violence, anger management difficulties, blurred boundaries regarding the privacy of family members, family abuse histories, and parental problems coping with the child's alleged sexual misconduct. In addition, the younger group had significantly higher levels of social isolation and current life stresses.

Types and Classifications

Although, as noted below, some research studies have substantially advanced the body of knowledge about younger children who are sexually abusive and their difficulties, longitudinal studies following these children over time are lacking. Thus, it is not known whether childhood sexual behavior problems continue or, more accurately, which children persist in their sexual misconduct in adolescence or through adulthood.

Children who have sexual behavior problems are a heterogeneous group. Descriptions of these children typically differentiate normative sexual behavior exhibited by children from a continuum of progressively

⁵ The authors (Pithers et al., 1998a) noted that psychometric test results were reported for female caregivers only (94.5 percent of the sample), to facilitate the comparison of their scores with published norms.

more excessive and abusive sexual behaviors (Araji, 1997; Johnson, 1991).

For example, Johnson (1991) described children referred for evaluation or consultation because of reported sexual acting-out behavior and identified four groups: normal sexual exploration, sexually reactive, extensive mutual sexual behaviors, and child perpetrators. Factors that distinguish these groups are as follows:

- ◆ Normal sexual exploration is an “information-gathering process” that involves children looking at and touching each others’ bodies and trying out gender roles. The sex play is voluntary and typically involves same-age children. It usually is spontaneous and light hearted.
- ◆ Sexually reactive children have been sexually abused, have been exposed to pornography, and/or live in highly sexualized households. The behaviors of these children include exposing, touching the genitals of other children or adults, self-stimulating genitals or inserting objects, and so on. The emotions associated with these behaviors may reflect confusion and shame.
- ◆ The children in the extensive mutual sexual behavior group participate in extensive sexual behaviors on a continuous basis, including oral sex, vaginal intercourse, and anal intercourse. They do not appear to experience anxiety, guilt, shame, or confusion, and they evidence little desire to stop. The sexual activity is mutual; there is no offender or victim. Most of these children have previously been sexually abused. Sometimes their sexual behavior appears as a coping strategy in very chaotic, dysfunctional, and/or sexually abusive families. Some of these children have been placed in multiple foster homes and appear to cling to each other in this sexual way to assuage their feelings of fear and loneliness.
- ◆ The child perpetrator group includes children who engage in impulsive, compulsive, and aggressive sexual behavior. The sexual behaviors are not mutual and involve coercion, trickery, bribery, and force. The children in this group often associate feelings of anger and aggression (and sometimes rage) with sex. Other feelings associated

with sex include fear, loneliness, or abandonment. These children typically have been exposed to high levels of sexual violence (including incest), promiscuity, pornography, and sexualized relationships.

Based on her literature review and her own research, Araji (1997) also conceptualized a subgroup of children who are comparable to children in Johnson’s child perpetrators group. These “sexually aggressive children” are at the extreme end of a childhood sexual behavior continuum. Their sexual behaviors tend to be more aggressive and involve force, coercion, and secrecy. Their sexually abusive behaviors typically are repetitive and may increase in frequency over time. Araji also suggested that the sexually abusive behaviors of these children may indicate a need to reduce negative emotions (such as anger, fear, or loneliness) and may also express a felt need for power. Araji stated that these children require intense, specialized interventions and are likely to be the most resistant to treatment.

In what appears to be the first attempt to develop empirically derived and clinically relevant classifications of children with sexual behavior problems, Pithers et al. (1998b) studied a sample of 127 children ages 6 to 12 who had evidenced sexual behavior problems. The authors defined “problematic” as sexual behaviors that were “(a) repetitive; (b) unresponsive to adult intervention and supervision; (c) equivalent to adult criminal violations; (d) pervasive, occurring across time and situations; or (e) highly diverse, consisting of a wide array of developmentally unexpected sexual acts” (p. 386).

Pithers et al. (1998b) found that children who evidenced sexual behavior problems varied significantly on several factors, including historical, demographic, behavioral, and diagnostic factors. They also varied according to number of victims, degree of aggression used during the sexual abuse, sexual penetration, psychiatric diagnoses, and internalizing and externalizing behaviors. Five subtypes were identified: sexually aggressive, nonsymptomatic, highly traumatized, abuse reactive, and rule breaker. Factors that distinguish these subtypes are as follows:

- ◆ The sexually aggressive children tended to have the highest rates of conduct disorder diagnoses. They were more likely to penetrate their victims and less often were victims of sexual or physical abuse themselves.
- ◆ The nonsymptomatic children were, as the classification name implies, within the normal range on most test measures. They typically did not have psychiatric diagnoses, evidenced low levels of aggression in their sexual behaviors, and had the fewest victims. These children were some of the most likely children to have in their extended family persons who had perpetrated sexual abuse.
- ◆ Both the highly traumatized children and the abuse reactive children typically were among the youngest and had the highest average number of victims. These two groups of children also had been victimized by the greatest number of sexual and physical abuse perpetrators.
- ◆ The highly traumatized children had the highest incidence of psychiatric diagnoses and posttraumatic stress disorders. Their parents were more likely than other parents to report feeling less attached to their children.
- ◆ The abuse reactive children had the shortest time between their own personal victimization experiences and the onset of their abuse against others. They experienced a high level of maltreatment and had a high number of sexual abuse perpetrators. This group had a high incidence of psychiatric diagnoses and the highest incidence of oppositional defiant disorders. They occasionally used aggression during their offenses.
- ◆ The rule-breaking group included a higher number of girls and had a greater time lag between their own victimization experiences and the onset of their abuse against others. These children had higher levels of sexualized and aggressive behaviors and also were more likely to act out in non-sexual ways. They had the highest number of sexual abusers within their extended families.

Across all five subtypes, certain factors were found to be associated with the number of victims abused by these children. The children who themselves had

been abused by more perpetrators and the children who had impaired attachments with their parents had greater numbers of victims.

Juveniles With Developmental Disabilities and Mental Retardation Who Have Committed Sex Offenses

In one of the few studies focusing on adolescent sex offenders with mental retardation, Gilby, Wolf, and Goldberg (1989) compared sexual behavior problems in a sample of intellectually normal (defined by the authors as borderline intellectual functioning or higher) and mentally retarded (including mild and moderate mental retardation) adolescents. The sample included both outpatient and inpatient adolescents at an assessment and treatment center for children and adolescents. The authors found that the frequency of sexual behavior problems of the groups studied did not differ significantly according to their levels of intellectual functioning. They noted that, for both the “intellectually normal” and “mentally retarded” groups, the closer the adolescent was observed (e.g., within a residential setting), the greater the number of sexual behavior problems recorded. This finding was especially true for the mentally retarded inpatient group. The authors suggested that reports of a greater-than-expected number of sexual problems among persons with mental retardation may be related to the increased levels of supervision these individuals receive.

Gilby, Wolf, and Goldberg (1989) found increased levels of inappropriate, nonassaultive sexual behavior (e.g., exhibitionism and public masturbation) among the adolescents with mental retardation. Although the rate of sexual assault did not vary between the intellectually normal and mentally retarded groups, there were fewer “consented to” sexual activities among the mentally retarded outpatient group. The authors suggested that this difference could reflect a lack of opportunity. The authors also noted that sexual activity was frequent in both groups of adolescents once they were placed in residential settings. The adolescents with mental retardation, however, reportedly were more indiscriminant in their sexual activity: they were more

likely to engage in both homosexual and heterosexual activities, whereas the adolescents with normal intellectual functioning were more likely to engage exclusively in either heterosexual or homosexual activity.

Analysis of offense patterns in the intellectually normal and mentally retarded groups revealed that both groups engaged in both consensual sexual behavior and assaultive and other inappropriate sexual behaviors. Adolescents with mental retardation, however, had a higher rate of sexual assaults against peers and were less likely to know their victims. Adolescents with normal intellectual functioning selected female victims more often, whereas those with mental retardation were equally likely to select male and female victims.

The Gilby, Wolf, and Goldberg (1989) study is informative. Additional research is needed, however, to determine whether the findings in this study can be generalized to other juveniles with mental retardation who have committed sex offenses.

Likelihood of being sexually victimized may be a special issue among juveniles with mental retardation and other developmental disabilities. Cowardin (as cited in Stermac and Sheridan, 1993) reported that developmentally disabled persons are four times more likely than nondisabled individuals to be sexually abused. Also, individuals with developmental disabilities usually are not encouraged to date and marry or to express their sexual needs (Brantlinger, as cited in Stermac and Sheridan, 1993) and typically are relatively uneducated about sexual matters (Edmondson, McCombs, and Wish, as cited in Stermac and Sheridan, 1993).

Juveniles Who Have Committed Sex Offenses Versus Other Types of Offenses

Given limited resources (funding and availability of treatment programs and providers) and reported similarities between juvenile sex offenders and other juvenile delinquents, the question arises as to how extensive the differences are between individual sex offenders and between sex offenders as a group and

other juveniles who have been abused and traumatized and have had very difficult lives. Are juveniles who have committed sex offenses a distinct group in need of specialized intervention, or can their needs be best met through interventions that are effective with juveniles who have committed other types of offenses?

Again, research is limited. Available studies, however, suggest that juveniles who commit sex offenses and juveniles who commit other types of offenses share many characteristics (e.g., Miner and Crimmins, 1995).

Milloy (1994) conducted a comparative study of 59 juvenile sex offenders and 132 other juvenile offenders as part of a needs assessment survey. She found that although the juvenile sex offenders had some unique characteristics, they shared many more characteristics with juveniles whose offenses were nonsexual. In contrast to the juveniles whose offenses were nonsexual, the sex offenders were more likely to have been victims of sexual abuse, have major mental health problems, need health or dental hygiene education, lack appropriate peer relationships, and have problems with sexual identity. They also tended to have more adequate academic performance, fewer prior offenses and convictions, and less substance abuse. None of the sex offenders was convicted of a new sex offense. Their overall recidivism rate was lower than that of other offenders. When they did reoffend, their crimes tended to be nonsexual and nonviolent. By the end of a 3-year followup period, only 22 percent of the sex offenders had offense histories limited to sex offenses only. Only 15 percent had been adjudicated for multiple separate incidents of sex offenses. In contrast, 78 percent had been convicted of both sex offenses and other types of offenses. Milloy noted, "These findings suggest that when a longitudinal perspective is used, sex offending among juveniles appears to be but one piece of a pattern of generalized delinquency" (p. 9).

Miner and Crimmins (1995) compared juveniles in juvenile sex offender treatment programs with juveniles who self-reported committing other types of offenses and juveniles who reported no delinquent behaviors in a national survey of juveniles. Few differences were found in the delinquency-related

attitudes of sex offenders and other offenders (e.g., whether it is okay to cheat on tests, be truant, use drugs, be violent, and commit theft). The sex offenders differed, however, from the other offenders in their overall negative attitude regarding most types of delinquent behavior. They also were more disengaged from family interactions. The authors proposed that it may be their social isolation from peers and family that allows juvenile sex offenders to violate a generally prosocial belief system and behave in antisocial ways toward others.

A more recent study by Spaccarelli et al. (1997) further supports findings suggesting that many

juvenile sex offenders also commit other types of offenses and are difficult to distinguish from delinquents with no known history of sexual assault. Spaccarelli et al. examined a sample of 210 chronic delinquents, 24 of whom had been arrested for a sex offense and 26 of whom self-reported committing sex offenses for which they had never been arrested. There were no differences on any of the measured variables between the combined group of 50 juvenile sex offenders and a group of 106 juveniles who had been arrested for violent but nonsexual offenses.

Assessment

Clinical Assessment

In view of the heterogeneous nature of juveniles who have sexually offended, comprehensive assessments of individuals are needed to facilitate treatment and intervention strategies. This includes assessment of each juvenile's needs (psychological, social, cognitive, and medical), family relationships, risk factors, and risk management possibilities. To emphasize this point, Dougher (1995) began his chapter describing the process of assessing sex offenders with the subtitle "Comprehensive, In-Depth Assessment Is Prelude to Effective Treatment Planning and Implementation" and pointed out that the literature emphasizes the varied, complex, and multidetermined nature of sex offending. Dougher further emphasized that "[a]ccordingly, any attempt to explain or treat sexually offensive behavior must consider the specific factors pertinent to an individual's offense and the psychological characteristics of the individual offender" (p. 11.2). He added that because many, ". . . if not most, sex offenders tend to lie about their offenses and are unreliable and deceptive in their verbal reports, the value of a thorough assessment cannot be overemphasized" (p. 11.2).

Gathering Multiple Sources of Information

Morenz and Becker (1995) noted that parents or guardians of juveniles should be involved in the assessment and in the treatment process. Informed consent should be obtained from the juvenile and parent or guardian, and they should be clearly informed of the limits of confidentiality (Becker and Hunter, 1997).

Recommended procedures for comprehensive assessment of juveniles who commit sex offenses

include clinical interviews with the juveniles and family members, psychological assessment, and, in certain cases (according to some), phallometric assessment (Bonner et al., 1998; Morenz and Becker, 1995). Structured clinical interviews (Morenz and Becker, 1995) and paper-and-pencil psychometric tests and questionnaires (Becker and Kaplan, 1993) also can be useful for assessing pertinent areas that may be related to sex offending, such as attitudes and values, social skills, psychological functioning, and sexual knowledge.

Becker and Hunter (1997) also noted that evaluators should review victim statements, juvenile court records, mental health reports, and school records as part of their assessments. Kraemer, Spielman, and Salisbury (1995) suggested that assessments should address the juvenile's beliefs regarding the sex-offending behaviors; issues of aggression, impulsivity, withdrawal, and depression; attitudes toward treatment; potential barriers to treatment; and approaches most likely to be effective. They also noted that objective measures to assess the prognosis for treatment outcomes are useful, citing as an example personality tests, which can help to identify individuals who are unlikely to succeed in treatment.

Using Psychological Tests

Psychological testing of sex offenders has a long history. Although not all of that history is positive, psychological testing is an important part of a comprehensive assessment (Dougher, 1995). In the past, testing was primarily used for identifying personality characteristics and psychological profiles of offenders; due to the heterogeneity of sex offenders, such attempts were not very successful. As Dougher pointed out, "Nevertheless, psychological tests can be useful in combination with other assessment

procedures to create a clinical picture of an offender and to identify target areas for clinical interventions” (p. 11.7). In fact, psychological tests have been described as adding a “critical dimension” to comprehensive evaluations of juveniles who have sexually offended (Kraemer, Spielman, and Salisbury, 1995). What they add is “a norm-based reference that can assist in determining placement in an appropriate treatment modality, developing a viable treatment plan, and assessing treatment progress” (p. 11.2).

Bourke and Donohue (1996), in their article “Assessment and Treatment of Juvenile Sex Offenders: An Empirical Review,” also observed that studies consistently reveal juvenile sex offenders to be a heterogeneous population. For example, they cited research findings that juvenile sex offending coexists with diagnoses of conduct disorders, attention deficit/hyperactivity disorders, antisocial personality disorders, narcissistic personality disorders, learning disabilities, affective disorders, posttraumatic stress disorders, and substance abuse. They concluded, “The high rate of comorbid diagnoses found within this population emphasizes the importance of utilizing sensitive, comprehensive, standardized methods when assessing and treating JSOs [juvenile sex offenders]” (p. 50).

Kraemer, Spielman, and Salisbury (1995) described four primary domains that require assessment: intellectual and neurological, personality functioning and psychopathology, behavioral, and sexual deviance. In addition, Becker and Hunter (1997) pointed out that psychometric testing to assess intellectual functioning and reading ability is important to ensure that the juvenile is able to understand both paper-and-pencil tests and treatment experiences.

The Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) has been described as the psychological test most widely used with juvenile sex offenders (Bourke and Donohue, 1996). Because of the heterogeneity of juveniles who have committed sex offenses, there is no MMPI sex offender profile that distinguishes these juveniles from others (Bourke and Donohue, 1996; Dougher, 1995). The MMPI-A’s strengths include its validity scales, which help the evaluator assess a juvenile’s attitude and approach to the evaluation. As Dougher pointed out, “The extent to which an offender is

dishonest, defensive, or malingering has obvious implications for treatment amenability and prognosis” (p. 11.8). The MMPI-A also may be useful for gaining insight into a juvenile’s personality and for assessing possible psychopathology (Bourke and Donohue, 1996; Dougher, 1995).

Bourke and Donohue (1996) also reviewed other psychological tests that have psychometric properties and that may be useful for identifying clinical issues and psychopathology relevant to the treatment of juvenile sex offenders. For example, the Multiphasic Sex Inventory (MSI) is an assessment instrument that is used with adult sex offenders to evaluate issues such as sexual interests, knowledge, fantasies, and behaviors. Bourke and Donohue expressed concern that only limited research has been conducted with the MSI; however, their review pertained to a 1984 version of the instrument. There is a juvenile version of the MSI, but it appears that even less research has been conducted with it than with the adult version. In their discussion of the adult MSI, Milner and Murphy (1995) also addressed the issue of limited validity data but stated that in spite of this important weakness, the MSI may have clinical utility for descriptive purposes in known offender groups. Milner and Murphy did not discuss the juvenile MSI.

A more comprehensive and promising approach involves computerized assessment with the Multi-dimensional Assessment of Sex and Aggression (MASA). The MASA, developed by Dr. Ray Knight, Dr. Robert Prentky, David Cerce, and Alison Martino, is a computerized, self-report inventory that covers multiple domains (Knight and Cerce, 1999; Knight, Prentky, and Cerce, 1994; Prentky and Edmunds, 1997). A juvenile version is currently being validated (R.A. Knight, personal communication, October 16, 2000). The questionnaire asks about attitudes and behaviors in many areas of an individual’s life, including childhood experiences, family and social relationships, school and work experiences, alcohol and drug use, and sexual and aggressive behavior and fantasies. The questionnaire includes items that have been associated with different classifications of offenders and with recidivism and includes sophisticated methods for assessing response biases, random responding, and dissimulation.

Studies have demonstrated that psychopathy is a strong predictor of violent behavior in general among adult offenders (e.g., Harris, Rice, and Quinsey, 1993; Quinsey, Rice, and Harris, 1995; Salekin, Rogers, and Sewell, 1996; Serin, 1996) and juvenile offenders (Forth, Hart, and Hare, 1990; Hare, 1991; Forth and Burke, 1998). Studies also have documented an association between psychopathy and sexual violence among adult offenders (Quinsey, Rice, and Harris, 1995; Serin et al., 1994). Studies investigating psychopathy and juvenile sex offending are more limited.

Gretton et al. (as cited in Forth and Burke, 1998) found that adolescent sex offenders who were diagnosed as psychopathic used more threats and more severe violence during their sex offense than those adolescent sex offenders who were classified as nonpsychopathic. Although relatively small proportions of adult sex offenders have been found to be psychopathic (Serin et al., 1994), adult sex offenders who are diagnosed with psychopathy and phallometrically assessed sexual deviance have been described as particularly dangerous (Hare, 1996).

Most studies of psychopathy use the Psychopathy Check List-Revised, a reliable and valid psychometric instrument specifically designed to assess psychopathy. Publication of the juvenile version of the Psychopathy Check List is expected soon (Forth, Kosson, and Hare, in press).

Assessing Deviant Sexual Arousal

To adequately assess individuals who appear to evidence deviant arousal, Weinrott (1998a) stressed the importance of using direct measurement of an individual's sexual arousal, through phallometric assessment (penile plethysmography). Becker et al. (as cited in Becker and Kaplan, 1993) reported preliminary research findings involving phallometric assessment that suggested deviant erectile responding was common in adolescents who had abused young boys and who had been sexually abused themselves.

Others, however, have discussed potential ethical concerns related to using phallometry with juveniles who have committed sex offenses (Bourke and

Donohue, 1996; Cellini, 1995). Concerns include the invasive nature of phallometric assessment, possible exposure of juveniles to sexual material beyond their experience, and limited research documenting the validity of phallometric assessment with juveniles. The limited research regarding the utility of phallometric assessment with juveniles who have committed sex offenses is partly due to ethical issues related to obtaining control groups. Weinrott (1998a) noted, however, that many of these issues could be addressed by using stimuli that are less sexually explicit in detail and language, because adolescents typically have strong responses to most sexually explicit stimuli. In addition, less explicit stimuli may increase the validity of phallometric assessment with juveniles.

Another psychophysiological assessment measure used with juveniles who have sexually offended is the Abel Assessment for Interest in Paraphilias (Abel Screening, Inc., 1996). The Abel Assessment is a computer-driven assessment approach that provides an evaluation of a juvenile's sexual interest patterns based on his or her reaction times when viewing slides of potentially sexually evocative stimuli. This methodology is significantly less invasive than phallometric assessment. Good reliability and significant correlations with diagnoses and self-reported arousal patterns have been reported (Abel Screening, Inc., 1996). However, an independent study of the Abel Assessment's reliability and validity raised questions about the use of this assessment approach with juveniles at this time (Smith and Fischer, 1999). The Abel Assessment is relatively new, and additional independent, published research is needed.

Using Other Assessment Strategies

Substance abuse assessment. In addition to the assessment of personality functioning and deviant arousal, it is also important to assess whether the individual has a substance abuse problem and, if so, whether it is a risk factor for that individual's sex offending. The importance of using valid and reliable assessment tools to screen for substance abuse difficulties has been emphasized (Becker and Hunter, 1997; Lightfoot and Barbaree, 1993).

Polygraph tests. Although controversial, the use of polygraph tests in treatment programs for juveniles who have been sexually abusive is increasing (National Adolescent Perpetrator Network [NAPN], 1993). The polygraph is used with some juveniles to facilitate more complete disclosures of sexually abusive behaviors and to monitor compliance with treatment. The National Task Force on Juvenile Sexual Offending noted that “[i]t is critical that submissions to polygraph examinations be voluntary and with full informed consent of the youth, parent, or guardian” (NAPN, 1993, p. 85). When disclosures during polygraph testing reveal previously unreported information, additional investigations can result. Furthermore, the Task Force pointed out that some professional organizations’ ethical requirements preclude the use of instruments without empirical evidence of reliability and validity. Research regarding the reliability and validity of the polygraph for assessing juvenile sex offenders is very limited (Hunter and Lexier, 1998). Some researchers have seriously questioned the validity of the polygraph (Cross and Saxe, as cited in Bonner et al., 1998; Saxe, Dougherty, and Cross, as cited in Bonner et al., 1998). Both false positives and false negatives occur, and the emotional impact of polygraph administration on juveniles and the resulting effects on the therapeutic process remain unknown (Hunter and Lexier, 1998).

Risk Assessment

Few empirical studies have investigated sexual reoffense rates among juveniles or risk factors associated with recidivism. Two retrospective studies that investigated the frequency of offenses prior to the referral offense found relatively high offense rates. Awad and Saunders (1991) investigated the sex offense histories of 49 juveniles who sexually assaulted peer or adult females and 45 juveniles who sexually abused younger children. They reported that 61 percent of those who sexually assaulted peers or adults had histories of prior sex offenses and that 40 percent of those who abused younger children had histories of prior molestation. Fehrenbach et al. (1986) found that 57.6 percent of the 297 juvenile sex offenders in their sample had perpetrated other sex offenses prior to their referral offense.

Rates of Recidivism

One prospective study followed juvenile offenders (19 who had committed sex offenses and 58 who had committed other types of offenses) into adulthood (Rubinstein et al., as cited in Sipe, Jensen, and Everett, 1998). Findings revealed that 37 percent of those who had committed sex offenses as juveniles went on to have criminal records for sexual assaults as adults, in contrast to 10 percent of those who had committed other types of offenses as juveniles. A weakness of this study was the relatively small sample size for sex offenders. A strength of the study was its relatively long followup period of 8 years. It may not be possible to generalize the study’s findings to other juveniles who have committed sex offenses, not only because the sample of sex offenders was small but also because it included juveniles described as very assaultive (a trait not representative of many juvenile sex offenders).

In contrast to the Rubinstein et al. study (as cited in Sipe, Jensen, and Everett, 1998), most studies have suggested that once a juvenile’s sex offending has been officially recognized, subsequent detected sexual recidivism is relatively infrequent (Bremer, 1992; Hagan, King, and Patros, as cited in Kramer et al., 1997; Kramer et al., 1997; Miner, Siekert, and Ackland, 1997; Rasmussen, 1999; Sipe, Jensen, and Everett, 1998; Weinrott, 1996). Sipe, Jensen, and Everett (1998) found that only 9.7 percent of their sample of 124 juveniles who had committed “nonviolent” sex offenses against children under 16 years old were subsequently arrested for a sex offense as an adult. Interestingly, 3 percent of a sample who had committed nonsexual offenses as juveniles were also arrested for a sex offense as an adult. Both groups were more likely to be arrested for nonsexual offenses as adults (16.1 percent of the juvenile sex offenders and 32.6 percent of the other juvenile offenders). Followup periods in the study ranged from 1 to 14 years, with an average of 6 years.

Smith and Monastersky (1986) examined the juvenile justice records of 112 juvenile sex offenders. During a 17-month period of time when they had the opportunity to commit an offense while in the community, 16 (14.3 percent) committed another sex offense and 39 (34.8 percent) committed a nonsexual offense.

Schram, Milloy, and Rowe (1991) followed 197 juvenile sex offenders after they completed 1 of 10 different treatment programs. The followup period ranged from 2 to 7 years. The study found that 37 percent had no new arrests. Of the 63 percent who had new arrests, only 12 percent were arrested for a sexual offense. Similarly, relatively few were subsequently arrested for violent felonies (15 percent). Most rearrests were for either nonviolent felonies (40 percent) or misdemeanors (53 percent). (The offense categories were not mutually exclusive, and the juveniles may have been rearrested for more than one type of offense.) The 2 years immediately following discharge from treatment represented the period of highest risk, especially for those treated in institutions. Although some of the juveniles may have offended later, results suggested that most reoffending occurred when the subjects studied were still juveniles. A very small subset of offenders (seven, or 4 percent of the sample) were deemed, for the purpose of the study, to be "chronic" offenders (defined as having two or more sex offense arrests after the referral offense or one prior and one subsequent sex offense arrest). The researchers found that most of the juveniles in their sample desisted from sex offending after their first sex offense arrest, adjudication, and treatment. They concluded that very few who commit sex offenses as juveniles go on to commit such offenses as young adults. This finding is consistent with that of Sipe, Jensen, and Everett (1998), who, as noted above, found that only 9.7 percent of their juvenile sex offender sample were arrested for sex offenses as adults.

Kahn and Chambers (1991) described 221 juvenile sex offenders identified by Schram and Rowe (as cited in Kahn and Chambers, 1991), who only included 197 in the study reported above (Schram, Milloy, and Rowe, 1991). The subjects in this sample were in the community with the opportunity to reoffend for an average time of 20.4 months. Not surprisingly, recidivism rates were similar to those found by Schram, Milloy, and Rowe (1991). Nearly 45 percent of the 221 juveniles in this sample were convicted of one or more subsequent offenses. Of those who recidivated, only 6.6 percent had new convictions for nonsexual violent crimes and only 7.5 percent had convictions for sex crimes.

More recently, Miner, Siekert, and Ackland (1997) followed 96 juveniles who participated in the Minnesota Department of Correction Juvenile Sex Offender Program. The average time at risk for the followup was 19.3 months. During the followup period, 27.2 percent were arrested for a crime that did not involve a person, 10.4 percent were arrested for a new crime against a person, and only 8.3 percent were arrested for a new sex offense.

Rasmussen (1999) also recently reported findings on factors related to recidivism rates among first-time juvenile sex offenders. Rasmussen's results were consistent with previous research in that 54.1 percent ($N=92$) of the sample committed a new nonsexual offense, whereas only 14.1 percent ($N=24$) committed a new sex offense. The relatively higher reoffense rates may reflect the comparatively long followup period of 5 years.

Table 2 summarizes results of the recidivism studies reviewed above. Two of the studies included comparison groups of juveniles who apparently committed only nonsexual offenses. As the table indicates, recidivism involving nonsexual offenses was consistently and significantly higher than recidivism involving sex offenses, for both juvenile sex offenders and comparison groups. Weinrott (1996) provided a more extensive review of studies investigating recidivism rates among juvenile sex offenders. The findings summarized herein are consistent with Weinrott's overall findings.

Methodological variations clearly influence recidivism rates (Prentky et al., 1997). These variations include issues such as the definition of recidivism (i.e., a new arrest versus a new adjudication), the adequacy of delinquency or criminal records, and the duration of the followup period (Prentky et al., 2000). Yet, as Weinrott noted:

What virtually all of the studies show, contrary to popular opinion, is that relatively few JSOs [juvenile sex offenders] are charged with a subsequent sex crime. Whether this is due to deterrence, humiliation, lack of opportunity, clinical treatment, increased surveillance, or inadequate research methodology is difficult to ascertain. (p. 67)

Table 2: Sexual and Nonsexual Recidivism by Juvenile Offenders

Study	Followup Period	Sexual Recidivism		Nonsexual Recidivism	
		Sex Offenders	Other Offenders	Sex Offenders	Other Offenders
Kahn and Chambers, 1991	M: 20 months ^a	8% ^b (N=221) ^c			
Miner, Siekert, and Ackland, 1997	M: 19 months ^a	8% (N=96)		38% (N=96)	
Rasmussen, 1999	M: 5 years ^d	14% (N=170)		54% (N=170)	
Rubinstein et al., as cited in Sipe, Jensen, and Everett, 1998	M: 8 years ^d	37% (N=19)	10% (N=58)		
Schram, Milloy, and Rowe, 1991	R: 2–7 years ^e	12% (N=197)		15% (violent felonies), 40% (nonviolent felonies), 53% (misdemeanors) ^f (N=197)	
Sipe, Jensen, and Everett, 1998	M: 6 years ^d R: 1–14 years ^e	10% (N=124)	3% (N=132)	16% (N=124)	33% (N=132)
Smith and Monastersky, 1986	M: 17 months ^a	14% (N=112)		35% (N=112)	

Notes: ^a M=mean time at risk in the community. ^b Percentages have been rounded off to the nearest whole number. ^c N=the total number of subjects in the group sample. ^d M=mean number of months or years followed by the study. ^e R=range. ^f Offense categories were not mutually exclusive, and the juveniles may have been rearrested for more than one type of offense.

Factors Associated With Recidivism

Becker (as cited in Friedrich, 1990) suggested that adolescent sex offenders were probably more likely to reoffend if one or more of the following factors were present: initial offending was pleasurable,

consequences for the offense were minimal, the deviant sexual behavior was reinforced through masturbation or fantasy, and/or the offender had social skills deficits. These factors appear to have good face validity but require additional assessment.

As noted above, Smith and Monastersky (1986) examined the juvenile justice records of 112 juvenile sex offenders. They found that very few selected predictor variables were associated with reoffending. Offenders described as having “unhealthy” attitudes regarding sexuality (i.e., those who naively denied normal adolescent sexual behavior) were less likely to reoffend by committing a sex offense and somewhat less likely to reoffend by committing a nonsexual offense. The only other statistically significant findings involved nonsexual reoffenses. Offenders who appeared to understand the exploitive nature of their sex offenses were less likely to reoffend nonsexually, and those who were unable to identify their personal strengths were more likely to reoffend nonsexually. Interestingly, a lack of depression and a willingness to explore the referral sex offense nondefensively were both marginally related to an increased rate of sexual reoffending and a reduced rate of nonsexual reoffending.

In the Smith and Monastersky study, some offense characteristics also were marginally associated with reoffending in general. Rapists were less likely to reoffend than those who committed seemingly less serious crimes. Those who offended against substantially younger victims (4 or more years younger than the offender) were less likely to reoffend. In contrast, those who committed offenses against strangers were more likely to reoffend sexually (and less likely to reoffend nonsexually) than those who offended against relatives or acquaintances. Lastly, those who had at least one recent offense against boys were described as “somewhat” more likely to reoffend sexually than those who offended only against girls.

Schram, Milloy, and Rowe (1991) found that juvenile sexual recidivists had higher rates of truancy, higher rates of thinking errors (erroneous perceptions, ideas, and beliefs that justify abusive behavior—e.g., blaming victims), and at least one prior sex offense. They also were much more likely to have deviant sexual arousal patterns, although this was not assessed with physiological measures. Sexual recidivism was not related to the type of referral sex offense, treatment location, or type of treatment received.

In Schram, Milloy, and Rowe (1991), those who did not reoffend generally were older, had less previous contact with the juvenile justice system, and were less likely to have school behavior problems or truancy. They also were significantly less likely to have been sexually abused or have a sibling who was abused. They were more likely to have social skills deficits and were significantly less likely to blame their victims or exhibit deviant arousal patterns.

Kahn and Chambers (1991) found (in Schram and Rowe’s sample, as cited in Kahn and Chambers, 1991) that only two variables were significantly positively associated with sexual reoffending: using verbal threats during the commission of the offense and blaming the victim for the crime. Surprisingly, denial of the offense was negatively associated with reoffense rates: none of the eight offenders who completely denied their offenses sexually reoffended. Although offenders with “therapist-identified” deviant arousal (i.e., assessed by clinical judgment) reoffended at a higher rate than those without deviant arousal (13 percent versus 6 percent), this difference was not statistically significant. Similarly, although offenders who victimized a child they knew but were not related to were more likely to be adjudicated delinquent for a new sex offense than those who were related to their victims, the difference was not statistically significant. It also is important to note that more than 50 percent of the adolescent sex offenders in this study had histories of nonsexual criminal offenses.

In their 1997 study of juvenile sex offenders, Miner, Siekert, and Ackland indicated that predictors of reoffending included penetrating the victim during the original sex offense and coming from an unstable home. In Rasmussen’s 1999 study of juvenile sex offenders, multivariate analyses revealed that sexual recidivism was associated with perpetrating sex offenses against multiple female victims; i.e., juveniles with a history of multiple female victims, as contrasted with a single female victim or multiple male victims, were more likely to sexually reoffend. This finding is contrary to Smith and Monastersky’s (1986) finding suggesting that juvenile sex offenders who sexually abused male victims may pose a higher risk of sexual reoffending. In addition, Rasmussen (1999) found that nonsexual recidivism among

juvenile sex offenders was related to having a relatively high rate of previous nonsexual offenses and to not completing treatment.

In spite of the various descriptions of characteristics identified in juveniles who have sexually offended, Weinrott (1998b) reported that very few characteristics have been empirically associated with sexual recidivism. He noted that these characteristics include the following (Weinrott, 1998b, p. 1):

- ◆ Psychopathy.
- ◆ Deviant arousal.
- ◆ Cognitive distortions.
- ◆ Truancy.
- ◆ A prior (known) sex offense.
- ◆ Blaming the victim.
- ◆ Use of threat/force.

Weinrott (1998b) reported that in contrast to what has been commonly thought, factors such as denial, abuse histories, and empathy deficits (among others) either have not been empirically associated with sexual recidivism (i.e., have not statistically accounted for significant variance in outcomes) or have simply not been investigated.⁶ This is not to say that interventions designed to address these factors (e.g., efforts to reduce social skills deficits or educate offenders about victim impact) are not effective in reducing sexual recidivism, only that there is no empirical evidence indicating they are effective.

For example, a recent study (Hunter and Figueredo, 1999) found that nearly 75 percent of the juveniles who did not evidence any denial of their sex offenses when beginning treatment successfully complied with treatment requirements during the 12-month period under study. In contrast, only 25 percent of

⁶ Weinrott (1998b) listed the following factors as lacking empirical evidence: "(a) denial of offense or sexual intent, (b) low motivation for treatment, (c) introversive or antisocial personality traits, (d) low intelligence, (e) social-skills deficits, (f) impulsiveness, (g) pornography use, (h) conduct disorder, (i) abuse history, (j) minority race, (k) family relationships/structure, (l) delinquency, (m) alcohol/drug abuse, (n) lack of empathy, and (o) length and type of treatment" (p. 1).

the juveniles who evidenced full denial complied with treatment during the same period. The authors reported that "attitudes of openness and accountability proved to be the best predictors of a positive treatment outcome" (p. 65). It is important to note that adjudication may have been a confounding variable in this study, given that most of the juveniles who were adjudicated completely acknowledged their offense and relatively few of those who had not been adjudicated did so. Thus, the adjudication process and its consequences may have contributed significantly to treatment compliance. Furthermore, this study did not investigate whether openness and accountability were related to reduced recidivism rates.

Prediction of Recidivism

In a recent commentary, Chaffin and Bonner (1998) pointed out that there are no true experimental studies comparing untreated and treated juvenile sex offenders and no prospective studies evaluating risk factors or the natural course of sexual offending. As noted above, empirically based typologies have received some attention; however, an actuarial risk assessment schedule with adequate empirical validation is lacking (NAPN, 1993).

Two studies have investigated the accuracy of recidivism predictions by program staff. Schram, Milloy, and Rowe (1991) found that treatment staff members very accurately identified offenders who presented a low risk for sexual reoffending, but some of these juveniles reoffended in other ways. In contrast, only 18 percent of juveniles who were identified by program staff as "at risk" or "dangerous" sexually reoffended during the period under study. It is possible, of course, that some of these at-risk or dangerous offenders actually reoffended but were not detected. This finding is consistent with others (e.g., Smith and Monastersky, 1986) and suggests that treatment providers may tend to overpredict sexual recidivism (and therefore keep offenders in treatment) rather than risk the dire consequences associated with failing to predict recidivism that comes to pass.

There are a number of explanations for the relatively poor accuracy of attempts to predict sexual (and violent) recidivism (Smith and Monastersky, 1986).

Sex offending is a relatively infrequent event. Predicting any low-frequency event is difficult. The hidden nature of sexual abuse may contribute to low reoffense rates because reoffending may tend to go undetected; however, juveniles who have already been identified as sex offenders may be followed more closely and have less opportunity to reoffend. Too short followup periods also may account for low predictive accuracy; some offenders may offend sometime in the future, but after the study period. Further, as Smith and Monastersky observed, "It may be that the low rate of sexual reoffending is due to lasting changes in the offender and/or his family as a result of being identified, evaluated, treated, adjudicated, and/or sentenced" (p. 135).

Other problems associated with poor predictive accuracy include the absence of pertinent information needed for decisionmaking and clinicians' overreliance on inadequate predictors (MacArthur Violence Risk Assessment Study, 1996). An additional confounding factor is conservative decisionmaking that occurs to avoid predicting that someone will not reoffend, when in fact they might (Smith and Monastersky, 1986). As researchers have noted (Smith and Monastersky; Webster et al., 1997), to enhance predictive accuracy, professionals should balance historical and actuarial information with clinical and situational information. Assessment of risk should address a variety of factors that pertain to the individual juvenile and the juvenile's environment and situational factors that could increase or reduce risk.

Ageton and her colleagues (as cited in Prentky et al., 2000) investigated the predictive utility of several measures and found that four variables correctly classified 77 percent of the juveniles who reoffended sexually: involvement with delinquent peers, history of crimes against persons, attitudes toward rape and sexual assault, and family normlessness. Subsequent analysis revealed that only one variable—

involvement with delinquent peers—was necessary to correctly classify 76 percent of the cases.

Prentky et al. (2000) have developed and conducted initial testing of an actuarial risk assessment schedule designed to assess the risk of reoffending among juvenile sex offenders. The schedule includes four factors: sexual drive/preoccupation, impulsive/antisocial, clinical/treatment, and community adjustment. The factors and individual items are based on literature reviews of studies pertaining to juvenile sex offenders, adult sex offenders, and juvenile delinquents in general. The risk assessment schedule was evaluated by following 96 juvenile sex offenders who had received treatment on an outpatient basis. The followup period was 12 months. Only 11 percent of the offenders who were studied committed any type of criminal offense during the followup period, and only three of these juveniles (4 percent of the sample) committed another sex offense. In evaluating the validity of the risk assessment schedule, Prentky et al. reported that, overall, the interrater reliabilities for the items (which indicate consistency in scoring between individual raters) were good to excellent and the scale alphas (which provide a conservative estimate of a measure's reliability) were quite good. Because of the very low base rate of sexual recidivism, the researchers were unable to evaluate predictive validity. Overall, however, the findings were encouraging. Data collection continues at a number of different sites to gather sufficient cases to permit a proper look at the usefulness of the schedule for assessing risk and predicting reoffending.

As Epps (1994) noted, potential problems in using risk assessment tools to predict juvenile sex offenders' likelihood of reoffending include difficulties in gathering reliable and valid information on which to base such instruments. Sufficient staff training and supervision also are important to ensure appropriate and reliable risk assessment.

Treatment

The National Task Force on Juvenile Sexual Offending consists of 20 members and 20 advisory members (NAPN, 1993). The Task Force was formed in 1986 after National Adolescent Perpetrator Network (NAPN) members (treatment providers and intervention specialists from more than 800 programs) supported the idea of creating a group to develop standards for the assessment and treatment of juvenile sex offenders. Recognizing that sufficient research did not yet exist to warrant a presentation of intervention standards, the National Task Force (as cited in NAPN) articulated a set of assumptions intended to reflect the current thinking relevant to a comprehensive systems response to juveniles who have sexually offended. These assumptions are summarized below.

- ◆ Following a full assessment of the juvenile's risk factors and needs, individualized and developmentally sensitive interventions are required.
- ◆ Individualized treatment plans should be designed and periodically reassessed and revised. Plans should specify treatment needs, treatment objectives, and required interventions.
- ◆ Treatment should be provided in the least restrictive environment necessary for community protection. Treatment efforts also should involve the least intrusive methods that can be expected to accomplish treatment objectives.
- ◆ Written progress reports should be issued to the agency that has mandated treatment and should be discussed with the juvenile and parents. Progress "must be based on specific measurable objectives, observable changes, and demonstrated ability to apply changes in current situations" (NAPN, 1993, p. 53).

- ◆ Although adequate outcome data are lacking, NAPN (1993) suggests that satisfactory treatment will require a minimum of 12 to 24 months.

Some individual States also have worked to develop appropriate protocols and standards for effective interventions with juveniles who have committed sex offenses. For example, Utah established a multidisciplinary team of professionals who developed a manual establishing guidelines for treatment and service delivery (Utah Task Force of the Utah Network on Juveniles Offending Sexually [Utah NOJOS], 1996).

Treatment programs for juvenile sex offenders have proliferated during the past decade. According to NAPN (1988), there were only 20 such programs in the United States in 1982. The 1994 Safer Society Program's national survey (Freeman-Longo et al.) identified 684 programs.

Continuum of Care Models

To adequately address both the needs of individual juveniles who have committed sex offenses and the needs of the community, a continuum of care is recommended (Bengis, 1997; NAPN, 1993). Offering a range of interventions and placement options makes it possible to provide cost-effective interventions while placing paramount importance on community safety. Such a continuum, as described in the *Oregon Report on Juvenile Sex Offenders* (Avalon Associates, 1986), may include:

- ◆ Short-term, specialized psychoeducational programs.
- ◆ Community-based outpatient sex offender treatment programs for juveniles remaining at home or in foster care.

- ◆ Day treatment programs.
- ◆ Residential group homes or residential facilities.
- ◆ Training schools for short-term placements providing assessments and facilitating readiness for community-based treatment.
- ◆ Secure units providing comprehensive, intensive treatment, including daily unit groups; two to three small daily groups focusing on interpersonal skills; weekly sessions on a variety of topics, such as sex offending issues, stress cycles, anger management, and social skills; parent groups; family therapy; individual treatment; substance abuse therapy, if needed; and more.

The *Oregon Report* recommended individualized assessments, although the comprehensiveness of the assessments might vary depending on individual needs. Such assessments guide appropriate placement along the continuum of care and also guide individualized interventions and treatment.

Bengis (1997) also described a comprehensive continuum of care with similar components, such as:

- ◆ Locked residential treatment facilities.
- ◆ Unlocked residential treatment units made secure by staff.
- ◆ Alternative community-based living environments, such as foster care, group living homes, mentor programs, or supervised apartments.
- ◆ Outpatient groups, day programs, and special education schools.
- ◆ Diagnostic centers and services specifically designed to provide assessments tailored to sex offenders in addition to traditional diagnostic assessments.

Bengis (1997) pointed out that at different points during their treatment, juveniles may require different levels of supervision and treatment intensity. He stressed that to be most effective, the components of the continuum should have consistent treatment philosophies and approaches and, whenever possible, should provide stability in treatment providers as the juvenile moves along the continuum.

The Utah Task Force (Utah NOJOS, 1996) also recommended a continuum of care. In addition to the placements described above, the task force included inpatient assessment and stabilization and psychiatric treatment. It described a continuum for both adolescents and preadolescent children.

Treatment Approaches

Overview

The NAPN (1993) stressed that the primary objective of interventions with juveniles who have sexually offended is community safety. Cellini (1995) described the primary goals of treatment interventions with these juveniles as helping them to gain control over their sexually abusive behaviors and to increase their prosocial interactions with peers and adults. Similarly, Becker and Hunter (1997) described the main treatment objectives as preventing further victimization, halting the development of additional psychosexual problems, and helping the juvenile develop age-appropriate relationships with peers.

To accomplish these goals, highly structured interventions, frequently involving written treatment contracts, are recommended (Morenz and Becker, 1995). Treatment approaches include individual, group, and family interventions. Although group therapies often are described as the treatment of choice (NAPN, 1993), empirical support for this claim is lacking (NAPN, 1993; Weinrott, 1996). Similarly, cotherapy teams, preferably involving a female therapist and a male therapist, also are recommended (NAPN, 1993), but the necessity of such teams has not been demonstrated.

As Marshall and Barbaree (1990) noted in their review of the effectiveness of adult cognitive-behavioral sex offender treatment programs, most cognitive-behavioral programs combine individual treatment approaches with group therapy. Individual treatment typically addresses sexual preference interventions and some aspects of social functioning. Marshall and Barbaree pointed out, however, that individual therapy is expensive and often is not cost effective. Group therapy can be a more efficient means of concurrently presenting the

educational components of treatment to a number of offenders. Furthermore, male-female therapist teams can model egalitarian relationships between the sexes for group members, and group members may be able to draw on their own experiences as offenders to provide valuable insights into other offenders' difficulties. Marshall and Barbaree also noted that group processes can facilitate new ways of thinking and social interaction that are unavailable in "traditional individualized treatment." On the other hand, the potential advantages of group therapies must be weighed against the possible disadvantages related to negative peer group associations, as have been identified in the juvenile justice field (e.g., Fagan and Wexler, as cited in Henggeler, Melton, and Smith, 1992).

The first step in treatment typically involves helping the juvenile accept responsibility for his or her behavior (Becker and Hunter, 1997). A number of factors (e.g., legal defense strategies and parental disbelief), however, can make this a difficult task. Minimizing and denying abusive behavior are common responses and are typically viewed as problematic (NAPN, 1993). Barbaree and Cortoni (1993) noted that denial is so often considered such an obstacle to effective treatment that many programs will not accept individuals who are unremitting in their denial. Barbaree and Cortoni also observed, however, that once the juvenile sex offender's denial and minimization are reduced, the offender can begin to empathize with the victim. Barbaree and Cortoni consider the reduction of denial and minimization and the development of empathy with the victim to be the necessary "first step" in facilitating the offender's motivation for treatment and behavior change.

Recommended treatment content areas for juveniles who have sexually offended typically include sex education, correction of cognitive distortions (cognitive restructuring), empathy training, clarification of values concerning abusive versus nonabusive sexual behavior, anger management, strategies to enhance impulse control and facilitate good judgment, social skills training, reduction of deviant arousal, and relapse prevention (Becker and Hunter, 1997; Hunter and Figueredo, 1999; NAPN, 1993). Other relevant interventions include training in vocational

and basic living skills, assistance with academics, resolution of personal victimization experiences, assistance with coexisting disorders or difficulties, resolution of family dysfunction and impaired sibling relationships, and development of prosocial relationships with peers, dating skills, and a positive sexual identity (Becker and Hunter, 1997; Hunter and Figueredo, 1999; NAPN, 1993). Research comparing adolescent sex offenders with a group of runaways found that the former were especially deficient in their general knowledge about AIDS and safe sex practices (Rotheram-Borus, Becker, Koopman, and Kaplan, as cited in Becker and Kaplan, 1993). Given this finding, the importance of focusing treatment on sexually transmitted diseases and safe sex is obvious.

Goocher (1994) noted that leaders in the field of juvenile sex offender treatment, such as Judith Becker and John Hunter, have argued that programs designed to focus exclusively on sex-offending behaviors are of limited value and have recommended a more holistic approach. Goocher further pointed out that, in view of the individual needs and developmental histories of these juveniles, "quasi-corrections models" of addressing sex offending are not adequate. Goocher noted that many residential treatment programs for juvenile sex offenders have been based on quasi-corrections models of treatment adapted from work with adult sex offenders. Goocher also observed how, in one program, staff seemed to replicate the juveniles' power and control behaviors and secretive behavior in the staff's own interactions among themselves and in their interactions with the institution's managers, with other units, and with the juveniles. He recommended that the staff in such programs be sensitive to their positions as role models and guides for juveniles who are attempting to move beyond their life experiences and offense histories and that staff receive adequate training to enable them to perform this function.

Miner and Crimmins (1995) identified social isolation from positive interactions with peers and families as a possible factor that may explain why some seemingly prosocial juveniles engage in sexually aggressive acts. They suggested that treatment efforts should break the process of social isolation and noted that most programs do this through group

and social-cognitive interventions. They further recommended family interventions and facilitation of positive school attachments and positive emotional attachments in general as treatment goals.

Weinrott (1998a) noted that some treatments that are theoretically sound but have not been empirically related to sexual recidivism may also be appropriate for juvenile sex offenders. For example, Weinrott, noting that truancy is empirically associated with sexual recidivism, recommended that treatment actively target improved school performance. In addition, because appropriate and effective dating skills can increase access to appropriate sexual partners, Weinrott and others (e.g., Bourke and Donohue, 1996) emphasized development of dating skills as a treatment component. Weinrott also encouraged more aggressive interviewing techniques, such as interrogation approaches used by law enforcement, to get through denial quickly so that treatment can proceed in a more timely fashion.

Although psychopharmacological interventions, including sex-drive reducing medications such as medroxyprogesterone, have been found to be effective in reducing sex offending in adult offenders, they can have serious side effects. Such medications, when used with juveniles, can have possible negative effects on normal development and growth. Consequently, ethical concerns related to the use of these medications with juveniles are substantial (Hunter and Lexier, 1998).

Other medications sometimes are used with juveniles as part of a comprehensive treatment approach. For example, Hunter and Lexier (1998) noted reports from the professional literature that describe the utility of selective serotonin reuptake inhibitors (SSRI's). Lane (as cited in Hunter and Lexier, 1998) reported that SSRI's often have sexual dysfunction side effects such as suppressed sexual desire and delayed ejaculation. However, as Hunter and Lexier noted, the role of serotonin in regulating sexual behavior is not fully understood. Many questions concerning psychopharmacological approaches remain. These questions include which juveniles are likely to benefit from such an approach and at what dosages (Hunter and Lexier, 1998).

Addressing Deviant Arousal

Weinrott (1998a) stressed that juvenile sex offenders with deviant sexual arousal should be provided with treatment that effectively addresses this problem. Most programs that address deviant arousal do so through covert sensitization, a treatment approach that teaches juveniles to interrupt thoughts associated with sex offending by thinking of negative consequences associated with abusive behavior (Becker and Kaplan, 1993; Freeman-Longo et al., 1994). Weinrott raised the concern that this technique, as typically used, may not be vivid enough to be effective for adolescents who might not have the language abilities to design effective fantasies to counter deviant thoughts or who may simply find the task too boring. He also stated that behavioral conditioning with noxious stimuli, such as ammonia and, possibly, low-intensity electric shock, may be effective. The National Task Force on Juvenile Sexual Offending, however, advised that use of aversive therapies with juveniles is controversial (NAPN, 1993). It recommended that, when used, aversive stimuli should be self-administered by the juvenile, with appropriate consent from the juvenile, parent, and referring authority. Although the National Task Force advised against electric shock, it did not elaborate as to why adequate safeguards cannot be effectively applied.

Some treatment approaches that have been used with sex offenders, such as masturbatory satiation, are designed to render deviant fantasies or thoughts boring through repetition (Becker and Kaplan, 1993). Masturbatory conditioning, however, has presented practical as well as ethical concerns, because the approach requires asking the juvenile to masturbate, and may include masturbating to deviant stimuli with the goal of ultimately reducing such arousal (Becker and Kaplan, 1993; Bourke and Donohue, 1996; Morenz and Becker, 1995). Furthermore, as Hunter and Lexier (1998) observed, empirical findings concerning the effectiveness of any arousal conditioning approach are confounded by the inclusion of these approaches as part of a comprehensive treatment program. Consequently, Hunter and Lexier concluded that very little is known about the effectiveness of these approaches for reducing deviant arousal or about the types of juveniles for whom they may be most effective.

Vicarious sensitization (VS) is a relatively new treatment technique that may avoid some of the ethical concerns presented by other approaches. VS is a form of aversive conditioning that pairs deviant arousal with negative experiences. It involves exposing the juvenile to audiotaped crime scenarios designed to stimulate arousal and then, immediately afterwards, showing an aversive video that presents the negative social, emotional, physical, and legal consequences of sexually abusive behavior. Weinrott, Riggan, and Frothingham (1997) reported a study comparing a group of juvenile sex offenders who were administered a course of VS with a group who were on a waiting list but who had not yet received VS. Both groups received standard cognitive therapy during the study period. Phallometric assessment and self-report measures at 3 months revealed significantly reduced deviant arousal for the juveniles who had received VS. Furthermore, although the juveniles on the waiting list did not improve during the study period, they evidenced improvement after they received VS treatment. Although noting the limitations of a 3-month followup period, Weinrott and colleagues described VS as a technique that, used in conjunction with specialized cognitive therapy, may be an effective approach for reducing deviant arousal in juveniles who are sexually aroused by prepubescent children. As in all areas of sex offender treatment, additional research is needed to assess the effectiveness of this approach, including its long-term effectiveness.

Involving Families

Rasmussen (1999) argued that adequate family support can help reduce recidivism and that treatment programs that involve families are likely to be more effective than those that do not. As Gray and Pithers (1993) observed, however, families vary in terms of their motivation and ability to effectively facilitate their child's treatment. Gray and Pithers described strategies that can engage the cooperation of family members and reported that parents found the following approaches useful:

- (1) written information on relapse prevention, cognitive distortions, and the consequences of sexual abuse;
- (2) educational videotapes of adolescent abusers discussing their relapse process

and the need to be held accountable; (3) literature on the recovery process of sexual abuse victims; (4) referrals to treatment groups for adult survivors of sexual abuse; (5) the opportunity to be included periodically in sessions of the adolescent abuser group; (6) support groups for parents of abusive adolescents; and (7) attention to the concerns of the juvenile's siblings in the treatment process. (p. 314)

Lee and Olender (1992) described a teaching-family model of community-based residential treatment that has been used with juvenile sex offenders and other children. They noted that this specialized foster care approach can be very restrictive and can provide intensive treatment in a more homelike atmosphere, depending on the program components required for a particular child at a particular time. Through this approach, juveniles receive interventions in a more naturalistic setting, enabling them to acquire and practice prosocial life skills in situations similar to everyday life. The approach focuses directly on behaviors and uses a systematic reward program (a token economy) to enhance positive motivation. It also uses cognitive-behavioral approaches to facilitate behaviors such as impulse control, effective problem solving, moral and ethical decisionmaking, and so on. Foster parents trained to be "teaching parents" use techniques that have been researched and found useful for managing intense and emotionally volatile behaviors, and they use a curriculum to facilitate skills necessary for social competence and independent living. Foster parents are provided with support services, and juveniles participate in group counseling interventions. Lee and Olender reported that initial implementation research, conducted as part of the Ohio Youth Services Network's evaluation of sex offender treatment programs throughout the State, found that the program provided "high quality, appropriate care of adolescent offenders and emotionally disturbed youth" (p. 74). Outcome research is under way.

Using a Relapse Prevention Model

Relapse prevention initially was designed to help substance abusers prevent reoccurrence of substance-abusing behavior. Then Pithers, Marques, Gibat, and Marlatt (as cited in Barbaree and Cortoni, 1993)

applied relapse prevention to adult sex offenders to reduce sexual reoffending. Gray and Pithers (1993) applied relapse prevention to the treatment and supervision of children and adolescents with sexual behavior problems.

Relapse prevention requires that juveniles learn to identify factors associated with an increased risk of sex offending and use strategies to avoid high-risk situations or effectively manage them when they occur. Gray and Pithers (1993) noted, however:

A high degree of motivation and integrity is required for a client to continually monitor signs of his relapse process and to invoke coping strategies, even when it feels like a sacrifice to do so. Without the dedication derived from the empathy for sexual abuse victims developed in treatment, RP [relapse prevention] risks becoming an intellectual exercise that educates offenders about what they need to do to avoid reoffending but that finds offenders lacking the motivation to use this knowledge. (p. 299)

When relapse prevention is applied to children, greater emphasis is placed on external supervision to prevent further victimization (Gray and Pithers, 1993). The relapse prevention approach is theoretically sound; however, as with other components of treatment for juveniles who have sexually offended, empirical studies investigating the effectiveness of this approach are lacking.

Summary

Some of the interventions described above appear appropriate for some juveniles who have committed sex offenses, but others do not. Furthermore, many of the target areas described above are relevant not only for sex offenders but also for juveniles who commit other types of offenses. In view of the many studies identifying general delinquency and antisocial attitudes and behavior among juveniles who exhibit sexual behavior problems, Weinrott (1998a) suggested that relevant empirically based treatment interventions for juvenile delinquents be used with those who commit sex offenses, whenever the interventions are indicated. Similarly, as Rasmussen (1999) stressed, "Treatment programs should be

structured to address the factors that contribute to and maintain *all* criminal behavior, not just sexual offending" (p. 81).

Prentky (1995, 1997) presented potential target areas of treatment for juvenile and adult sex offenders and corresponding modalities for intervention. Although most of the modes of treatment presented by Prentky are discussed in this literature review, a few have not been mentioned, such as childhood victim survivors' group therapy and expressive therapy.

Table 3 provides a guide to treatment intended to reduce offending behaviors. It incorporates Prentky's (1995, 1997) work, treatment and modalities discussed in this literature review, and the authors' clinical understanding of these issues. The table presents clinical interventions but does not cover other strategies such as supporting appropriate academic placements, school attendance, and vocational training. As emphasized throughout this literature review, individualized assessment should guide the development of an appropriate treatment plan for each individual; the information presented in table 3 should not be rigidly applied.

Research on Treatment Efficacy

Specialized Treatment for Juveniles Who Have Committed Sex Offenses

In spite of the proliferation of programs specifically designed for juvenile sex offenders, evaluation of these specialized approaches has been limited. For example, as Weinrott (1996) observed, most sex offender treatment programs have learning about the "sexual assault cycle" at their core. The cycle is used to help juveniles conceptualize their offending behaviors, including the associated feelings and distorted thinking that contribute to and follow their abusive acts. Becker (1998) described the cycle concept that was developed by Ryan, Lane, Davis, and Isaac (as cited in Becker, 1998). The concept is based on the premise that offending is preceded by a negative self-image that contributes to negative coping strategies when the juvenile anticipates negative responses from others, perceives such responses, or both. To avoid such negative anticipated

Table 3: Treatment To Reduce Offending Behaviors

Modes of Treatment	Target Areas of Treatment						Consequences of Personal History of Child Maltreatment
	Impaired Social Relationships	Empathy Deficits	Cognitive Distortions	Deviant Sexual Arousal	Problematic Management of Emotions	Impulsive/Antisocial Behaviors	
Anger Management	X		X		X		
Assertiveness Training	X				X		
Aversion Therapy				X			
Childhood Victim Survivors' Group	X	X	X		X		X
Cognitive Restructuring	X	X	X		X	X	X
Covert Sensitization				X			
Expressive Therapy		X			X		X
Family Interventions	X	X	X		X	X	X
Group and Individual Therapy	X	X	X	X	X	X	X
Multisystem Interventions (e.g., MST and MTFC)	X	X	X		X	X	X
Pharmacotherapy				X	X	X	
Positive Identification Development	X		X				X
Relapse Prevention and Offense Cycles			X	X	X	X	
Self-Control and Impulse Management				X	X	X	
Self-Help Groups	X					X	X
Sex Education and Dating Skills	X						
Social Skills Training	X						
Stress and Anxiety Management	X				X	X	
Substance Abuse Education and Treatment					X	X	
Systematic Desensitization	X			X			
Vicarious Sensitization				X			
Victim Empathy Training	X	X	X			X	

or perceived reactions, the juvenile withdraws, becomes socially isolated, and fantasizes to compensate for resulting feelings of powerlessness and a lack of control. This process culminates in the sex offense, which results in more negative experiences, more feelings of rejection, and an increasingly negative self-image; and the cycle continues.

Weinrott (1996) pointed out that in spite of the fact that the sexual assault cycle has been used in sex offender treatment for nearly 20 years, this model has not been empirically validated. Furthermore, as Weinrott noted, although the cycle may fit many juveniles who have committed sex offenses, it does not explain the abusive behavior of all such offenders, including those described as “naive experimenters,” those who desist from their abusive behavior, those who perpetrate sex offenses as part of a group, and those whose sexual behavior may be a result of significant psychopathology or deviant sexual arousal.

In their editorial, “Don’t Shoot, We’re Your Children: Have We Gone Too Far in Our Response to Adolescent Sexual Abusers and Children With Sexual Behavior Problems?” Chaffin and Bonner (1998) cautioned against the “conviction” that those working in the field have found the right approach. They wrote that such “dogma” might include the following beliefs:

That sex offender-specific treatment is the only acceptable and effective approach and that all teens and children who have performed inappropriate sexual behaviors must receive it; that a history of personal victimization is usually present, is a direct cause of abusive sexual behaviors, and must be a focus of treatment; that denial must be broken; that hard, in-your-face confrontation is synonymous with good therapy; that treatment must be long term and involve highly restrictive conditions; that deviant arousal, deviant fantasies, grooming [of victims] and deceit are intrinsic features; that parents and families of offenders are generally dysfunctional; that long-term residential placement is commonly required; that behaviors always involve an offense cycle or pattern that must be identified; that these teenagers and their parents must face the fact that they have a compulsive, incurable, life-long

disorder; and that these youngsters are such dangerous predatory criminals that neighborhoods must be notified of their presence. Despite their wide acceptance, it is our opinion that clear, empirical scientific support for each and every one of these conventional wisdoms is either minimal or nonexistent. (p. 314)

Chaffin and Bonner (1998) reported that they knew juveniles who felt required to “confess” to sex offenses they did not commit and to deviant fantasies they did not have, because they thought they would be discharged from the treatment program if they did not comply. The authors also expressed concern that “overly broad applications” of fantasy journals, addiction/compulsion programs, shaming approaches, and programs that aggressively encourage empathy with victims could negatively affect these juveniles. Chaffin and Bonner further pointed out that although rates of detected sexual reoffenses appear relatively low (around 5 to 15 percent), the lack of untreated comparison groups prevents us from knowing whether treatment has been effective. In fact, they stressed, “Empirically, we cannot say whether treatment helps, hurts, or makes no difference” (p. 316). Chaffin and Bonner’s views are consistent with Weinrott’s (1996), who stated:

The prevailing view is that early clinical intervention is needed to break the cycle of sexual deviance, and that intervention should take the form of lengthy, offense-specific, peer-group therapy. There is not a shred of scientific evidence to support this stance. (p. 85)

Chaffin and Bonner (1998) and Weinrott (1996) have observed that at this point, it is not possible to say whether one type of treatment is better than another, with the possible exception of delinquency-focused multisystemic treatment, which appears to be more effective than individual counseling with juveniles who have committed sex offenses. Furthermore, as Weinrott noted, there also is no evidence to support a “heavy handed” correctional or justice response.

A study that appears to raise questions about the efficacy of specialized treatment for juveniles who have committed sex offenses was conducted by Lab, Shields, and Schondel (1993). The researchers

compared the recidivism rates for juveniles treated in a specialized sex offender treatment program with rates for juveniles referred to community-based treatment programs generally lacking specialized programs for sex offenders. The study found that recidivism rates for both groups were low and that the outcome for juveniles treated in the sex-offense-specific program was no better than that for those treated in non-offense-specific programs. Like Chaffin and Bonner (1998), Lab, Shields, and Schondel concluded, "These results suggest that the growth of interventions has proceeded without adequate knowledge of how to identify at-risk youth, the causes of the behavior, and the most appropriate treatment for juvenile sex offending" (p. 543). Methodological problems, however, may have compromised the utility of this study (Weinrott, 1996).

In contrast to the Lab, Shields, and Schondel (1993) findings are results from a study by Kimball and Guarino-Ghezzi (1996), who compared 75 juvenile sex offenders treated in sex-offense-specific programs with sex offenders treated in non-offense-specific programs. Although placement in treatment programs was not randomized, juveniles did not vary significantly on their prior record, previous sexual deviance, or exposure to sexual, physical, and substance abuse. Findings revealed that juveniles placed in sex offender treatment demonstrated more positive attitudes and greater skill acquisition than those in nonspecific treatment. They were more likely to accept full responsibility for their offenses, to express remorse related to victim impact, and to articulate practical relapse prevention concepts and strategies. They also were significantly more successful in completing their first aftercare placements (70.6 percent, versus 41.2 percent for nonspecific treatment placements). At the time of this report, followup results were limited to 6 months. Findings suggested that participation in sex offender treatment contributed to lower rates of reoffending.

Although the Kimball and Guarino-Ghezzi (1996) treatment outcome results appear encouraging, these findings are tempered by other findings indicating that participants in the sex offender programs received more treatment than those in nonspecific programs. Those placed in sex-offense-specific treatment programs received significantly more therapy sessions, including group sessions that focused

specifically on offending behavior. They also received significantly more family therapy (51.8 percent, versus 30.8 percent for those in nonspecific treatment). In addition, they received more treatment for nonsexual factors contributing to their sex offending; such treatment included family therapy, interpersonal skills training, stress and anxiety management, and relapse prevention. They also remained in treatment for significantly longer periods than those who received nonspecific programming (an average of 15.7 months, versus 7.1 months in nonspecific treatment). Thus, it is unclear whether a non-offense-specific treatment program comparable to a sex offender treatment program in terms of intensity and breadth of services would yield outcome results comparable to those of the Kimball and Guarino-Ghezzi study, especially for offenders who do not evidence patterns of deviant arousal.

In another study, Becker (as cited in Weinrott, 1996) described the effectiveness of cognitive-behavioral treatment used with a sample of juveniles who abused children younger than themselves. In addition to psychoeducational and cognitive approaches, this treatment used interpersonal skills training and behavioral interventions to reduce deviant arousal. Results indicated a 10-percent recidivism rate for sex offending. This finding, however, was based only on juveniles who completed the program. Furthermore, the followup period was relatively short (1 year), and no control group was used.

Weinrott (1998a) noted that in spite of the limited treatment research, empirically based approaches should be emphasized in the treatment of juvenile sex offenders. For example, he encouraged practitioners to provide juvenile sex offenders who engage in various types of delinquent behaviors with empirically based treatment approaches that have been designed specifically for delinquent populations.

Treatment for Juveniles Who Are Delinquent

The following studies describe research that has assessed the effectiveness of interventions with juveniles who commit various types of offenses, not just sex offenses. As previously noted, because general delinquency and antisocial attitudes and behavior are frequently found in juveniles who have

committed sex offenses, these treatment approaches may be relevant and effective with these juveniles.

Izzo and Ross (1990) conducted a meta-analysis of rehabilitation programs designed for all juvenile delinquents, not just those who have committed sex offenses. Their findings suggested that programs based on cognitive therapy were twice as effective as those using other approaches. They defined cognitive therapy as approaches that employed one or more of six intervention modalities: problem solving, negotiation skills training, interpersonal skills training, rational-emotive therapy, role playing and modeling, and cognitive behavior modification.

More recently, Lipsey and Wilson (1998) conducted a meta-analysis of 200 experimental or quasi-experimental studies to assess the effectiveness of treatment interventions used with juvenile offenders. Because of variability between treatment approaches and sample characteristics, the findings from this meta-analysis require further study and should in the meantime be considered to be suggestive only. The findings are, however, consistent with reviews of the literature (Tolan and Guerra, 1994) and previous meta-analytic results (Lipsey, as cited in Lipsey and Wilson, 1998).

In sum, Lipsey and Wilson (1998) found that among noninstitutionalized juveniles, treatments that focused on interpersonal skills (e.g., social skills training, anger management, and moral education) and used behavioral programs consistently yielded positive effects. Contrary to findings from previous studies (Lipsey, as cited in Lipsey and Wilson, 1998; Tolan and Guerra, 1994), individual counseling also showed consistent positive effects. This surprising finding may be a result of the types of interventions that this study considered as "individual counseling." One approach involved a 12-week reality therapy program that emphasized client accountability and responsibility, behavior assessments, and action plans.

The other treatment that was included in the "individual counseling" category was multisystemic therapy (MST) (Lipsey and Wilson, 1998). MST is an empirically based intervention that has been validated with chronic juvenile delinquents and substance-abusing juveniles (Henggeler et al., 1998). It is also the only approach that has been

empirically validated as effective with juvenile sex offenders (Borduin et al., 1990), although the sample size in the validation study was small and the comparison treatment did not involve current treatment approaches. MST confronts antisocial behavior in juveniles by targeting their "social-ecological context" (i.e., their family, neighborhood, school, and community) (Henggeler et al., 1998). Thus, although interventions may (or may not) involve individual interventions with the juveniles, this approach certainly cannot be considered individual counseling in the usual sense. MST individual interventions, for example, may involve parent figures, with or without the juvenile present. The importance of MST for juvenile sex offenders has increasingly been noted (Bourke and Donohue, 1996; Cellini, 1995; Swenson et al., 1998).

Results of the meta-analysis (Lipsey and Wilson, 1998) further indicated that other interventions with noninstitutionalized juvenile offenders have shown positive but less consistent evidence of effectiveness. These interventions include programs that provide multiple services (e.g., vocational training, skills-oriented education, job placement, community supervision) and those that require restitution or supervision through probation and parole. Mixed but generally positive effects were found in some studies for the following interventions: employment-related services, academic programming, advocacy and casework approaches, and family and group counseling. In contrast, weak or no effects were consistently found for early release, deterrence, vocational, and wilderness/challenge programs.

Findings regarding institutionalized juvenile offenders indicated consistent, positive effects for programs that focused on interpersonal skills (Lipsey and Wilson, 1998). One treatment approach, the teaching-family home model mentioned previously (Lee and Olender, 1992; Lipsey and Wilson, 1998), involves juveniles who frequently are referred from detention facilities or placements more restrictive than foster care. The teaching-family home model uses "teaching parents" to help juveniles develop necessary life skills and enhance social competence.

Positive but less consistent results were found for behavioral programs, community residential approaches, and programs that provided multiple

services. Inconsistent evidence of mixed but generally positive effects was found for individual counseling, guided group interventions, and group counseling. In contrast, weak or no effects were consistently found for milieu therapy approaches.

Lipsey and Wilson (1998) noted that the impact of the most effective treatments on recidivism was substantial:

The most effective treatment types had an impact on recidivism that was equivalent to reducing a .50 control group baseline to around .30. In other words, we estimated that without treatment the recidivism would have been 50%. If they received the most effective of the treatments reviewed in this meta-analysis, their recidivism would have dropped to about 30%. (p. 333)

Chamberlain and Reid (1998) contrasted traditional community group placements with multidimensional treatment foster care (MTFC) to investigate an alternative to MST for juveniles whose parents were unable, for various reasons, to provide the “corrective or therapeutic parenting” the juveniles needed. Like MST, MTFC involves multiple treatment modes and targets, including individual therapy, family therapy, and interventions at home, at school, and among peer groups. In the Chamberlain and Reid study, chronic juvenile delinquents, including some juvenile sex offenders, were randomly assigned to either MTFC or traditional community-based group care settings. Results indicated that juveniles in MTFC had significantly fewer justice system referrals and returned home to relatives more often than those in community-based group care settings. Multiple regression analysis showed that assignment to the MTFC treatment condition was a better predictor of reduced offense rates (official and self-reported) than other well-known predictors.

Attrition From Sex-Offense-Specific Treatment

Studies of treatment programs for juveniles who have sexually offended have demonstrated high rates of treatment dropouts. For example, Becker (1990) found that only 27.3 percent of her sample

attended 70 to 100 percent of scheduled therapy sessions and only 45.4 percent completed at least half of the sessions. Kraemer, Salisbury, and Spielman (1998) reported that completion rates for residential juvenile sex offender programs in Minnesota appeared to range from 30 to 50 percent. Their study suggested that older age and impulsivity were associated with treatment dropout. Rasmussen (1999) found that only half of the subjects in her sample completed the initial stage of their treatment and one-third failed to complete the full course of treatment once they began. (The remaining subjects either were not referred for treatment or did not follow through on the referral.) Schram, Milloy, and Rowe (1991) found that most offenders terminated treatment as soon as their sentence or court order ended. Only 39 percent of their sample completed treatment.

Similarly, Hunter and Figueredo (1999) reported that more than 50 percent of the subjects in their sample terminated or were terminated from treatment during the first year. Although 20 percent of these juveniles ended treatment for reasons unrelated to their behavior or attitudes (e.g., family relocation), 33 percent were expelled from the program as treatment failures. Of the “treatment failures,” more than 75 percent were terminated because they were noncompliant with attendance and therapeutic directives. Only 11.4 percent of the “treatment failures” were terminated because of recidivism (4.9 percent for sex offenses, 6.6 percent for other types of offenses).

In another study, O’Brien (as cited in Weinrott, 1996) found that only 6 percent of 200 juvenile sex offenders who completed a treatment program committed another sex offense after being referred to the program. Although the study did not provide information about the number of juveniles who dropped out of treatment prematurely, the researchers did note that half of the juveniles who reoffended did so before they completed the treatment program.

High rates of treatment attrition are extremely important. Studies with juvenile sex offenders (Hunter and Figueredo, 1999) and adult sex offenders (Becker and Hunter, as cited in Rasmussen, 1999; Hanson and Buissière, 1998; Marques, Day, Nelson, and

West, as cited in Hunter and Figueredo, 1999; Marshall et al., as cited in Rasmussen, 1999) suggest that failing to complete treatment is associated with higher rates of recidivism for both sex offenses and other types of offenses.

Treatment Setting

Segregating Versus Integrating Juveniles Who Have Committed Sex Offenses

Historically, treating juveniles who have committed sex offenses in a setting specifically designed for sex offenders has been considered “optimal” (Morenz and Becker, 1995). The literature, however, indicates that the effectiveness of this approach has not been proven. In fact, as some of the studies reviewed above suggest, other approaches (e.g., MST and MTFC) may be more beneficial. Noting the absence of significant differences between groups of juvenile sex offenders and other juvenile offenders in the research that they and others have conducted, Jacobs, Kennedy, and Meyer (1997) concluded, “The similarities are indicative of commensurate therapeutic needs for both types of offenders” (p. 201).

Milloy (1994) asked the question, “But what is specialized sex offender treatment?” She pointed out that “specialized” treatment for sex offenders typically includes components such as sex education, social skills, anger management, acceptance of responsibility for one’s offenses, and empathy for victims. Yet these components may be appropriate for juvenile offenders in general.

As Milloy (1994) pointed out, one of the arguments in favor of specialized and segregated sex offender treatment programs is that these offenders frequently intimidate staff and other residents through their manipulative or aggressive behaviors. The results of Milloy’s study, however, suggested that juveniles who committed sex offenses were not more likely to be exploitative, manipulative, or aggressive than juveniles who committed other types of offenses. The frequency of verbal and physical threats did not differ between the groups, and the sex offenders did not present increased management risks or security risks within the institution.

In conclusion, Milloy (1994) indicated that no controlled studies have been published investigating the effect of segregating juvenile sex offenders from the general delinquent population. She stated, “This fact, coupled with the findings from this study, suggest that the segregation of juvenile sex offenders is a costly approach whose worth is unproven” (p. 10).

Whether juveniles who have been sexually abusive should be grouped with juveniles who have committed nonsexual offenses or with juveniles who have other behavioral problems is a complex issue. Clearly, other factors must be considered when designing appropriate treatments and treatment settings. Among these factors is the safety of all juveniles involved, since the juveniles who have committed sex offenses might become targets themselves or might target others.

Another factor cited as supportive of segregated treatment units is the reduction of staff training needs that results when intensive training in sex-offending issues is provided only to those whose jobs involve this specialized treatment (Bengis, 1997). Other arguments in favor of segregated units include the possibility that such units may form stronger and more effective treatment cultures (Bengis). On the other hand, research has suggested that delinquent peer group association may increase risk (Ageton, as cited in Prentky et al., 2000). Controlled studies using random assignment to comparison groups are necessary to help resolve the issue of whether juveniles who have committed sex offenses should be segregated from other juveniles in residential care.

In the meantime, the importance of individualized assessment and treatment planning cannot be over-emphasized. As Kavoussi, Kaplan, and Becker (1988) point out, the heterogeneity of juvenile sex offenders “suggests that no single treatment regime will be effective in all cases” (p. 243). Furthermore, a one-size-fits-all approach can be costly and may be harmful to the juveniles and their families (Becker, 1998). As Chaffin and Bonner (1998) point out,

[P]erhaps it is time to emphasize some flexibility and compassion in which treatments we choose and to which individual youngsters we apply them and to realize that individual need, not dogma, should dictate what must be accomplished (p. 316).

Facilitating Safety in Residential Treatment Settings

The issue of community safety exists regardless of whether a juvenile sex offender remains in the community or is placed in a segregated or unsegregated residential facility. NAPN (1993) provided specific recommendations to facilitate safety in residential treatment facilities. These recommendations suggest that such programs should ensure the following:

1. A systems based program design for sexual abuse prevention in the institutional setting, which includes (a) policies and procedures reflecting an open and safe system that addresses safety, children's rights, and familial rights; (b) procedures for selecting, screening, training, and supervising staff to decrease the risk of sexually abusive behavior; (c) staff guidelines for interventions with residents; (d) safety education for residents; (e) protocols ensuring environmental safety; (f) procedures addressing allegations or disclosures of sexual abuse; and (g) internal evaluations and external reviews.
2. A strong, structured behavior management program where management and control of behavior is maintained through program structure and staff/patient interactions.
3. A safe therapeutic environment and an effective therapeutic milieu.
4. Close staff supervision based on a high staff-patient ratio and continuous monitoring by staff of all interactions. Video and audio monitors and sensors may also be in use in common areas but do not replace staff presence.
5. A therapeutic milieu which includes a facility safe environment, secure space, a strong peer culture, and a program philosophy which is consistent throughout.
6. A structured, well-balanced program which provides modalities developed to impact on adolescent problems and which allows very little unstructured time.
7. Highly trained staff who have received specialized training in child sexual abuse issues,

with emphasis on treatment of youthful victims and sexually abusive youth.

8. A multidisciplinary, multimodal design to impact on the treatment issues of both victims and sexually abusive youth.
9. A positive human sexuality program that emphasizes the development of positive attitudes about sexuality, healthy relationships, and safe sexual practices.
10. Ongoing, planned program evaluations. (pp. 75–76)

Other recommendations from the National Task Force on Juvenile Sexual Offending (as cited in NAPN, 1993) include having clear rules about personal space boundaries and touching. Recommendations also include having night staff who remain awake and monitor residents both randomly and at frequent, planned intervals throughout the night. Ross and Villier (1993) provided more detailed recommendations related to screening program applicants, selecting staff, and designing and supervising living units in a way that maximizes the safety of residents and staff.

Special Populations

Treatment of Young and Preadolescent Children With Sexual Behavior Problems

Gray (as cited in Araji, 1997) proposed that treatment goals that balance community safety and the promotion of developmentally appropriate competencies are most effective in treating children with sexual behavior problems. More specifically, Gray and Pithers (1993) suggested that abusive behaviors might be most effectively addressed by targeting risk factors that predispose a child to sexual behavior problems or that precipitate or perpetuate the problems. Gray and Pithers proposed the following approaches:

1. Enhancing self-management skills of sexually aggressive children.
2. Resolving trauma resulting from the child's own victimization.

3. Addressing compensatory reactions often associated with externalization of difficult emotions through problematic behaviors.

4. Increasing the extent to which prevention team members model abuse-preventive beliefs and intervene when abuse-related behaviors are observed. (p. 308)

Another component of treatment for children with sexual behavior problems is the “prevention team” (e.g., selected family members, care providers, and community advocates) (Gray and Pithers, 1993). The prevention team is of primary importance when intervening with young children who do not have the developmental capacity for self-monitoring.

According to Johnson (1991), interventions with children who are sexually abusive and aggressive should involve reporting the sexual behaviors to appropriate agencies, such as protective services and the police; working with appropriate agencies to ensure the safety of the victim, potential victims, and the abusing child; and working with the courts responsible for juveniles. Johnson observed that interventions should begin with an assessment of the child’s treatment needs, to facilitate appropriate placement and treatment.

In her book, Arajii (1997) described 10 treatment programs and practices for children with sexual behavior problems, including Johnson’s (as cited in Arajii). Arajii identified these programs by reviewing the professional literature and attending workshops and through personal correspondence. She stated that the programs described simply represent current treatment efforts and trends, noting that the effectiveness of most of the programs has not been demonstrated. The federally funded work of Pithers et al. (1998a, 1998b), as described below, and the ongoing work of Bonner, Walker, and Berliner (as described in Arajii, 1997) are important exceptions.

Most of the programs reviewed by Arajii use theories from the sex abuse literature. Some appear to emphasize personal histories of sexual abuse as a factor contributing to sexual behavior problems in children, although the literature suggests that this issue may be overemphasized in the context of multiple risk factors.

The programs reviewed by Arajii also used child development literature and designed interventions that were appropriate to different ages and cognitive and developmental levels. Programs typically targeted prevention of perpetration. Techniques frequently involved modifications of approaches used with adults or adolescents who commit sex offenses, such as the relapse prevention and assault cycle approaches discussed previously.

All of the programs reviewed used a cognitive-behavioral approach, although some also used other orientations, such as those based on psychodynamic and attachment theories. Cognitive-behavioral interventions included skill development to promote prosocial coping and problem solving, age-appropriate interpersonal relationships and sexual behaviors, and abuse prevention strategies. In her review, Arajii noted that because no treatment approach has been demonstrated to be superior to others, treatment that combines theories and methods might better meet the needs of these children and their families.

Treatment modalities in the programs reviewed by Arajii include individual, group, pair, and family therapy. Most providers appeared to prefer group therapies. Arajii’s views appear consistent with those of Johnson (1991), who stated: “The group format allows the therapists to use the group members to help each other understand and work on the ‘touching’ problems. The aim is to help the children interact without being sexually or behaviorally inappropriate” (p. 11). Arajii also noted that groups can help reduce children’s social isolation and are efficient in terms of cost and time. Others (Friedrich and Gil, as cited in Arajii, 1997) consider pair therapy (two children treated together) more beneficial. Advocates of the pair therapy approach believe that it may minimize anxieties, avoid rejections, and enhance controlled peer interactions.

Developmental issues. Other factors considered of great importance when intervening with children who have been sexually abusive are developmental issues. As Friedrich (as cited in Arajii, 1997) noted, substantial differences may exist between a 6-year-old child who has been sexually aggressive and a 10-year-old child who has been sexually aggressive. Even if the acts appear similar, differences may

include the meaning the child attributes to the act, differences in peer relationships, and other factors (including, for a child who has been the victim of sexual abuse, the length of time between the victimization and the child's abusive behavior).

Friedrich (as cited in Araji, 1997) also argued that sexual aggression in children reflects difficulties with a child's ability to modulate emotions and behavior. Sexual aggression is considered to be similar to other behavioral and psychological problems or disorders, such as fire setting, stealing, and posttraumatic stress disorders. Interventions found effective with these other forms of behavioral and emotional dysregulation—such as increasing parental supervision and positive interactions with parents—can be valuable for children who have been sexually abusive and may be sufficient for eliminating such behaviors in some children. Friedrich also argued that when children have suffered traumas, the underlying issues that may have resulted require intervention if positive, lasting changes are to be achieved.

Family involvement. Although the programs reviewed by Araji (1997) varied in terms of the range of interventions they provided to parents or other caregivers, all of them involved parents or other caregivers, either in group interventions or through other approaches. Treatment goals with caregivers typically included improving parental supervision and parenting skills and increasing parental knowledge about sex abuse; in some programs, treatment goals also included providing specific training to help parents help their children succeed at relapse prevention. In view of the high levels of stress, personal and interpersonal difficulties, and impaired parent-child attachments found in their study (as described previously, in the section on “Young Children Who Have Committed Sex Offenses: Family Characteristics”), Pithers et al. (1998a) noted the need for group treatment for parents of children with sexual behavior problems. Pithers et al. suggested that such groups address issues of parental attachment, parental training, social-relational skills, trauma resolution, and, when indicated, the opportunity to grieve the loss of an idealized child and family.

Specialized therapeutic foster homes have been developed in some areas to provide interventions for

children who are sexually abusive and require out-of-home placement but not residential care. One small study (Ray et al., 1995) involved 15 children who came from chaotic, violent, and abusive homes and were placed in therapeutic foster homes. These youngsters typically were under 13 years old, but occasionally older children with cognitive difficulties were accepted into the program. Researchers found that the children evidenced improvements in behavior, emotional adjustment, social functioning, family relationships, and overall adjustment. Improvements in life skills were not statistically significant but appeared to be moving in the expected direction. Although four of the children displayed inappropriate sexual behavior early in treatment, none of the children continued to do so at the completion of treatment. Followup interviews indicated that the children continued to have serious emotional and behavioral problems, but with the exception of two of the children, their sexually abusive behavior appeared to have subsided. This study is limited by its small sample size, lack of a comparison group, and other problems. In spite of these limitations, however, the advantages of foster care approaches in helping to stabilize a child and provide appropriate interventions warrant further study.

As Araji (1997) noted in her book, “Sexually abusive behavior by children is a complex phenomenon presented by multiproblem youth and, frequently, multiproblem families. . . . The programs, agencies, and practices reviewed all recognize the importance of developing individualized treatment plans” (p. 184). In addition, Araji noted that although a variety of interventions may be required, ranging from community-based approaches to residential care, “helping families to create safe, predictable, and growth promoting relationships among family members is key to helping the sexually reactive and sexually aggressive child” (p. 187).

A comparative study. As noted previously (in the section on “Young Children Who Have Committed Sex Offenses: Types and Classifications”), Pithers et al. (1998b) identified five subtypes of children with sexual behavior problems: sexually aggressive, non-symptomatic, highly traumatized, abusive reactive, and rule breaker. Their investigations also revealed some differences in how children in various subtype classifications responded to different types of treatment.

At intake, the children and their families were randomly assigned to one of two 32-week treatment conditions. One treatment involved expressive therapy, reportedly recommended by some national experts as the treatment of choice for children with behavioral problems. The other treatment was a substantially modified form of relapse prevention. Both approaches involved parents in parallel group interventions. The Child Sexual Behavior Inventory-3 (CSBI-3) was used to measure progress.

Results indicated that children in most of the subtypes evidenced similar degrees of change regardless of treatment modality. The highly traumatized children, however, benefited significantly more from modified relapse prevention than from expressive therapy. In fact, highly traumatized children who were in expressive therapy actually evidenced a slight increase in sexualized behavior. The number of children classified as sexually aggressive evidencing a reduction in sexual behavior problems was slightly larger in expressive therapy than in modified relapse prevention therapy, but this finding was tempered by the fact that a similar number of children in expressive therapy who were classified as sexually aggressive had an increase in sexual behavior problems.

Results further indicated that children in some subtypes responded well to treatment, whereas those in other subtypes did not. For example, more than half of the highly traumatized children evidenced significant reductions in problematic sexual behavior after the first 16 weeks of treatment. In contrast, only 7 percent of the sexually aggressive children demonstrated significant decreases in their sexual behavior problems.

Treatment of Juveniles With Cognitive or Developmental Disabilities

Special interventions may be necessary for juveniles with intellectual and cognitive impairments. Furthermore, these juveniles may be difficult to engage in standard treatment approaches. Langevin, Marentette, and Rosati (1996) proposed that learning difficulties may affect therapy in at least two ways. First, during therapy sessions, a person with learning difficulties may not be able to process the same

information that a person of average intellectual abilities could. Second, individuals with learning difficulties may have developed negative attitudes toward learning situations and, "in particular, avoid classroom type experiences where they may have met failure and derision from other students" (p. 145). As a result, these individuals may prefer to avoid therapeutic situations that resemble their negative experiences, such as psychoeducational programs and other cognitive-behavioral approaches.

Langevin, Marentette, and Rosati (1996) found some support for these theories in their study of adult sex offenders. Although they did not find that the subjects' attitudes toward therapy were significantly related to education or level of intelligence, they did find a negative correlation between attitude and Halstead Reitan Impairment Index scores. In other words, individuals who evidenced significant neuropsychological impairment on the Halstead Reitan Index evidenced more negative attitudes toward therapy.

A review of the literature (Stermac and Sheridan, 1993) regarding treatment of "developmentally disabled" adults and adolescents revealed a "dearth of work in this area" (p. 237). Most studies have focused on adult offenders and have stressed behaviorally oriented interventions. Pharmacological approaches also have been used with developmentally disabled sex offenders. As noted previously (in the section on "Treatment Approaches: Overview"), sex-drive reducing medications such as medroxyprogesterone can be effective in reducing sex offending, but because of potentially serious side effects and ethical concerns, the use of these medications for juveniles requires appropriate informed consent from guardians; additionally, the appropriateness of these medications for juveniles who have committed sex offenses has been questioned (Hunter and Lexier, 1998).

Most interventions involving adolescents with developmental disabilities who have committed sex offenses have used approaches modified from adult sex offender treatment programs (Stermac and Sheridan, 1993). Strategies to enhance learning and generalizing skills and coping strategies are recommended. Modified relapse prevention strategies have been found to be effective with some cognitively impaired sex offenders. Yet, as Stermac and Sheridan

(1993) pointed out, relapse prevention emphasizes self-management and therefore may not be appropriate for all intellectually or cognitively impaired sex offenders.

Langevin, Marentette, and Rosati (1996) urged treatment professionals to reach out to these juveniles. They suggested the following steps:

- ◆ Address the juvenile's learning difficulties and attitudes at the outset.
- ◆ Use an individualized treatment and problem-solving approach that helps the juvenile resolve practical problems first before focusing on sex-offending issues.
- ◆ Reward strengths rather than focusing on weaknesses.

Research concerning intellectual, cognitive, and neurological impairments in juvenile sex offenders (previously discussed in the section on "Characteristics: Academic and Cognitive Functioning") also points to the necessity of developing individualized interventions that are tailored to the special needs of these juveniles. Although a more in-depth discussion of specialized interventions with juveniles who have intellectual, cognitive, and neurological problems is beyond the scope of this Report, Ferrara and McDonald (1996) provide a detailed discussion of treatment strategies and techniques that may be useful. These authors draw on work from other related fields, such as the treatment of persons with brain injuries, and apply this knowledge to interventions designed for juveniles who are sexually aggressive. For example, Ferrara and McDonald describe techniques designed specifically to facilitate learning, promote attention and concentration, and improve recall. Treatment approaches described are multimodal, applied in multiple settings, and tailored to the juvenile's individual needs.

Training and Qualifications of Treatment Providers

Individuals providing treatment for juveniles with sexual behavior problems must be personally and

professionally qualified (Association for the Treatment of Sexual Abusers, 1997a; NAPN, 1993). Personal qualifications include being emotionally healthy, having respect for oneself and others, using good listening skills, and having the ability to empathize. Professional qualifications include relevant education, training, and experience. Treatment providers should receive training before they begin their interventions. Training should then take place on a continuing basis, so providers can stay current with this evolving field.

More specifically, Goocher (1994) stressed the importance of "adequate training in normal adolescent development, the etiology and behavior manifestations of psychiatric disorders, and how to reinforce initial efforts of young people to learn new patterns of behavior and to come to terms with their own personal histories" (p. 249). Goocher also recommended additional training in how to help juveniles develop adequate verbal and personal skills and problem-solving abilities.

To be effective, Friedrich (as cited in Araj, 1997) suggested that therapists who work with sexually aggressive children should receive good training in issues pertaining to victimization and the development of violence and aggression. Araj (1997) noted that therapists also must be well aware of normative childhood sexual behaviors. Furthermore, the importance of developmental issues regarding attachment and the capacity for moral reasoning, empathy, and autonomy cannot be ignored (Pithers, Kashima, Cummings, Beal, and Buell, as cited in Araj, 1997). These suggestions clearly are important for those who treat adolescents and those who treat younger children.

Working with juveniles who have sexual behavior problems is a challenging job. In addition to concerns about protecting community safety, providing sound treatment, and dealing with significant human suffering, individuals who work with these juveniles are exposed to a great deal of distorted thinking and deviant sexual behavior. As NAPN (1993) observed, "Systems must be aware of potential emotional/psychological impacts on providers and take steps to protect against or counter negative effects" (p. 46).

Program Evaluation

Adequate program evaluation involves at least two primary approaches. First, implementation research is conducted to ensure that the components necessary for effective treatment exist and are implemented. Second, outcome research is necessary to determine whether the interventions have been effective. In spite of the important functions that program evaluation serves, evaluations of sex offender treatment programs have been few, and those that have been conducted often have had inadequate designs (Camp and Thyer, 1993). The literature provides some examples and ideas for future endeavors.

Most outcome studies have used recidivism rates to assess treatment effectiveness. Yet generally low rates of recidivism, short followup periods, variability in outcome measures (e.g., arrest or adjudication), and other methodological problems limit the usefulness of this approach. Other approaches to assessing treatment effectiveness are required.

Two studies have used self-report measures to evaluate the effectiveness of treatment programs. Hains, Herman, Baker, and Graber (as cited in Camp and Thyer, 1993) conducted pretreatment and posttreatment tests with adolescents in a residential sex offender program and with those on a waiting list. The researchers found significant improvements in social competency following treatment. In addition to examining recidivism data and parole violations, Miner, Siekert, and Ackland (1997) conducted pretreatment and posttreatment assessments with psychological measures such as the Jesness Behavioral Checklist and the Multiphasic Sex Inventory-Juvenile Revised (MSI-JR). As Kraemer, Spielman, and Salisbury (1995) noted, such self-report and objective measures provide a norm-based reference group that can be useful in assessing treatment progress.

Laben, Dodd, and Sneed (1991) used goal attainment theory to develop measurable outcomes in an inpatient juvenile sex offender treatment program. This approach required treatment providers and clients to establish mutual goals through a process of bargaining, negotiating, identifying commonalties, and defining measurable outcomes. Because initial group assessment indicated that treatment group members were very concrete in their thinking and had significant difficulties with verbal reasoning, researchers used visual aids to facilitate the goal attainment and treatment process. When a juvenile successfully completed each identified goal, a staff member would check it off on a written list. When all the goals were met, the juvenile's inpatient treatment was completed.

Goal attainment scaling (GAS) also was used in a study of hospitalized adult sex offenders (Lang, Lloyd, and Fiqia, 1985). In this study, patients and therapists developed individualized scaled descriptions of goals, which were measured to assess treatment outcome. Goals and treatment outcomes were measured on a scale ranging from -2 (least favorable outcome) to +2 (most favorable outcome), with 0 representing the expected treatment outcome. At followup, 38 patients had exceeded the "expected" success level, whereas 8 patients were found to have made minimal progress. The authors collapsed 176 of the 180 treatment goals into 4 primary content areas: sexual deviation (30 goals), anger and emotional expression (64 goals), self-concept (31 goals), and poor interpersonal relations (51 goals). The authors concluded: "As an adjunct to therapy, GAS can provide data on desired change over time on each patient's interpersonal, social, and psychosexual adjustment" (p. 536). They also noted that program quality assurance may be enhanced through retrospective reviews of goal attainment profiles and program improvements that result from the reviews.

The importance of program evaluation cannot be overemphasized. Also, as this literature review suggests, effective and humane interventions for juveniles with sexual behavior problems should be individualized, be empirically based whenever possible, facilitate family involvement, and, when program participation is indicated, promote program

completion. As Rasmussen (1999) suggested, “Administrators in the juvenile justice system would do well to provide support for those treatment programs that involve families, have specific goals and objectives, and carefully monitor successful completion of treatment” (p. 82).

Conclusions

The findings of this literature review indicate that juveniles who have committed sex offenses are a heterogeneous group who, like all juveniles, have developmental needs, but who also have special needs and present special risks related to their abusive behaviors. There currently are no empirically validated and accepted classification schemes for differentiating types of juveniles who have sexually offended. However, the relatively low known rates of recidivism and existing studies suggesting that a substantial proportion of these juveniles desist from committing sex offenses following the initial disclosed offense and intervention appear to support theoretical classifications. It may be that relatively smaller groups commit additional offenses, including sex offenses, other offenses, or both.

The literature on assessment and treatment clearly supports the importance of interventions that are tailored to the individual juvenile. Risk management strategies likely to be most effective are those that address the needs underlying a juvenile's behavior and make the most of the juvenile's existing strengths and positive supports. Treatment effectiveness is likely to be enhanced by interventions that motivate the juvenile to make positive changes and that facilitate efforts to do so by being responsive to learning or personality styles or other individual characteristics.

Interventions should target factors that are empirically associated with the risk of sex offending specifically (e.g., deviant arousal and limited social competence) and factors associated with delinquent offending in general (e.g., delinquent peers and anti-social attitudes). In addition, appropriate targets of

intervention include those that appear theoretically relevant but that either have not yet been studied or have not been demonstrated to be consistently related to risk (e.g., inadequate dating skills).

When selecting appropriate treatment programs and interventions, Chaffin and Bonner's (1998) cautionary remarks should be remembered. They observed that efficacy has not been established for many sex offender interventions considered standard and required. On the other hand, as this literature review has described, there is a wide range of interventions with more of an empirical basis, particularly within the juvenile justice field (such as MST), that may be effective. It also should be remembered that some juveniles may require minimal interventions once their sex offending has been disclosed. An additional—and important—caution is that treatment efforts certainly should not be harmful.

Lastly, it should be remembered that the goal when working with juveniles who have committed sex offenses is to help them stop their abusive behaviors. To label them "juvenile sex offenders" at a time when they are developing their identity may have deleterious effects. There is no evidence pertaining to these juveniles that suggests once a sex offender, always a sex offender, as Chaffin and Bonner (1998) point out in their editorial "Don't Shoot, We're Your Children: Have We Gone Too Far in Our Response to Adolescent Sexual Abusers and Children With Sexual Behavior Problems?" Instead, it is important to remember that they are children and adolescents first—they are young people who have committed offenses and who deserve care and attention.

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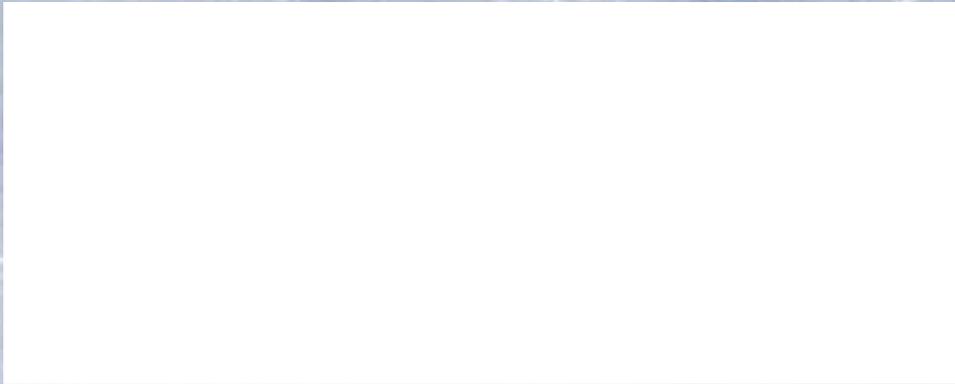
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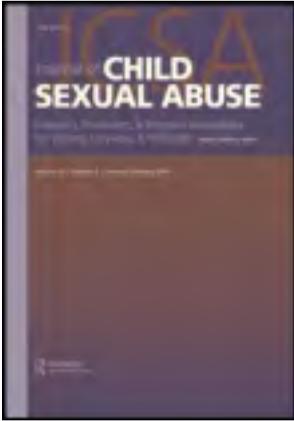


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Part II: Differences between Sexually Victimized and Nonsexually Victimized Male Adolescent Sexual Abusers and Delinquent Youth: Further Group Comparisons of Developmental Antecedents and Behavioral Challenges

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RESEARCH INVOLVING ADOLESCENT VICTIMS AND SEXUAL ABUSERS

Part II: Differences between Sexually Victimized and Nonsexually Victimized Male Adolescent Sexual Abusers and Delinquent Youth: Further Group Comparisons of Developmental Antecedents and Behavioral Challenges

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In a recent paper published in the Journal of Child Sexual Abuse, we assessed the differences between sexually victimized and nonsexually victimized male adolescent sexual abusers (Burton, Duty, & Leibowitz, 2011). We found that the sexually victimized group had more severe developmental antecedents (e.g., trauma and early exposure to pornography) and behavioral difficulties (sexual aggression, arousal, pornography use, and nonsexual offenses). The present study compares sexually victimized and nonsexually victimized adolescent sexual abusers with a group of nonsexually victimized delinquent youth. Findings included that delinquent youth had fewer behavioral and developmental problems than the comparison groups. In addition, sexually victimized

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sexual abusers had the highest mean scores on trauma and personality measures. Implications for research and treatment are offered.

KEYWORDS adolescent sexual offending, delinquency, sexual victimization, personality, sexual recidivism

The current study builds on the authors' previous research investigating the differences between sexually victimized and nonsexually victimized male adolescent sexual abusers (Burton, Duty, & Leibowitz, 2011). For a more expansive literature review on the developmental pathways to sexual aggression, the typological research, personality characteristics, and the risk for reoffense based on a history of sexual victimization, the reader is referred to the earlier paper. Findings of the earlier project corroborated previous research (Burton, Miller, & Shill, 2002; Hunter, Figueredo, Malamuth, & Becker, 2003) that a history of sexual victimization may be an etiological factor contributing to sexually abusive behavior among adolescents. Comparing sexually victimized and nonvictimized sexual abusers, our hypotheses were supported: the sexually victimized group exhibited greater developmental (trauma, family characteristics, early exposure to pornography, and personality disturbances) and behavioral challenges (characteristics of sexual aggression, sexual arousal, use of pornography, and nonsexual criminal behavior) compared to the nonvictimized group. The present study further contributes to the research and clinical literature by comparing sexually victimized and nonsexually victimized adolescent sexual offenders, with the addition of a group of nonsexually victimized delinquent youth.

COMPARISONS OF ADOLESCENT SEXUAL ABUSERS AND DELINQUENT YOUTH

Researchers have noted that there are relatively few studies comparing adolescent sexual offenders with nonsexual offenders (van Wijk et al., 2006). In addition, there are inconsistent findings across studies. Several researchers have found differences between adolescent sexual abusers and delinquent youth on a number of variables. For example, in their research review, van Wijk and colleagues (2006) found differences between the sexual and nonsexual offenders in personality, behavior, a history of sexual abuse, and nonsexual offending. In their oft-cited evaluation of the differences between sexual offenders, nonsexual violent offenders, and status offenders ($N = 89$), Ford and Linney (1995) reported mixed findings in terms of the similarities and differences between groups (e.g., regarding family criminal history) and they also found racial differences between groups. However, they did not control for race. Child molesters were sexually victimized more often than

status offenders in that study. The caveat about these projects and previous research findings in this area in general is that small sample sizes make it difficult to generalize findings. Moreover, there have been inconsistent findings with regard to differences on race (van Wijk et al., 2006). That is, researchers have found that adolescent sexual abusers were mostly Caucasian compared to delinquent youth, which is noteworthy in light of the fact that many investigators have not controlled for race or addressed multicollinearity. Burton and Ginsberg (in press) recently highlighted the racial differences found in comparison studies of these two groups and found that approximately 70% of youthful sexual abusers were Caucasian across studies. Consequently, we underscore the fact that race should be considered in all research involving comparisons of these groups.

In response to the larger question of etiological differences between sexual offending and nonsexual offending groups of adolescents, Seto and Lalumière (2010) recently completed a meta-analysis in which they investigated differences between juvenile sexual offenders and nonsexually offending delinquents on variables related to delinquency. In addition to the finding that adolescent sexual offenders were not as engaged in extensive nonsexual criminal behavior, they found that sexual victimization accounted for differences between the two groups (following atypical sexual interests), with the sexual offender group having higher victimization rates. Building on this research, we sought to compare victimized versus nonvictimized groups of adolescents, a method not as utilized in previous research.

In this paper, we refined our analysis to focus on salient variables based on the earlier paper and the prior literature review: developmental antecedents (trauma and personality disturbances) and behavioral challenges (nonsexual criminal behavior).

METHOD

We originally planned to include four groups; however, there were only 11 sexually victimized delinquents in our sample. Consequently, our analysis included three groups: sexually victimized sexual abusers ($n = 143$), nonsexually victimized sexual offenders ($n = 177$), and nonsexually victimized delinquent youth ($n = 152$).

Sample

The average age of the sample ($n = 478$) was 16.63 years ($SD = 1.54$ years) with no significant differences between groups on age using MANOVA ($F_{2,475} = 1.38, p = .25$). The age range was 12 to 20 years. Regarding grade level, no differences were found between groups ($F_{2,476} = 0.53, p = .59$); the average was 9th grade ($SD = 1.54$).

Of the sample, 38% were African American, 46% were Anglo-American, and 16% were other or multiracial. There were significant differences in racial composition between the groups, with more nonsexual offending African-American youth than Caucasian youth (56.3% African-American; 37.5% Caucasian) and nearly the opposite in the sex offending group: 50% were Caucasian, 28.8% were African American, and 21.2% identified as "other." Race was therefore included in subsequent analyses.

After consents were obtained, confidential data were collected from youth with sexual ($n = 325$) and nonsexual offenses ($n = 163$; henceforth referred to as "general delinquents") in six residential facilities in a Midwest state. Multipage pencil and paper surveys were collected. Eleven (6.7%) of the general delinquents reported that they had been sexually abused and were therefore taken out of the sample, resulting in 152 youth in the nonsexually victimized delinquent sample (93.3% from whom we collected data). In the total sample, 179 (55%) reported sexual victimization as children while 146 (45%) denied sexual victimization.

Measures

The measures used in this study as well as the results are divided into two categories: developmental antecedents and criminal behaviors.

DEVELOPMENTAL ANTECEDENTS

The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) is a 34-item scale that provides a brief and relatively noninvasive screening of traumatic experiences in childhood. All of the subscales have acceptable to good internal consistency in this study. Cronbach's alphas on the five CTQ subscales range from .83 (physical neglect) to .92 (emotional neglect; see Table 1).

The Millon Adolescent Clinical Inventory (MACI; Millon, 1993) was designed for youth in treatment or correctional facilities. It was normed on 579 adolescents in such facilities with two smaller cross-validation samples. The scales derived from the 160 true-false items are based on Millon's theory of personality (Millon & Davis, 1996). There are 12 personality pattern scales on the MACI, including those measuring introversive, inhibited, doleful, submissive, dramatizing, egotistic, unruly, forceful, conforming, oppositional, borderline tendency, and self-demeaning tendencies. Data from eight youth were eliminated from the study using Millon's validity scoring procedures. With the exception of the forceful scale ($\alpha = .35$), which was dropped from further analyses, the remaining scales had acceptable internal consistency, with Cronbach's alphas ranging from .68 for the unruly scale to .86 for the self-demeaning scale (see Table 2).

TABLE 1 Results of MANOVA for the CTQ Subscales[†]

Variables	Cronbach's α	Mean (SE) Sexually Victimized $n = 143^{**}$	Mean (SE) Nonsexually Victimized $n = 177^{**}$	Mean (SE) General Delinquents $n = 152^{**}$	DF	F*	p/effect size
CTQ					10,918	37.697	<0.001/0.291
Emotional Abuse	.90	12.45 ^a (0.42)	9.73 ^b (0.45)	6.80 ^c (0.43)	2,466	44.03	<0.001/0.160
Emotional Neglect	.92	19.79 ^a (0.71)	17.26 ^b (0.76)	16.69 ^b (0.73)	2,466	5.40	0.005/0.023
Physical Abuse	.91	13.02 ^a (0.44)	10.01 ^b (0.47)	7.30 ^c (0.45)	2,466	41.46	<0.001/0.152
Physical Neglect	.76	16.73 ^a (0.45)	14.43 ^b (0.48)	13.03 ^b (0.46)	2,466	16.78	<0.001/0.068
Sexual Abuse	.85	16.04 ^a (0.35)	7.44 ^b (0.38)	8.03 ^b (0.36)	2,466	186.72	<0.001/0.446

Note: Scales are presented alphabetically. Casewise deletion of missing data was used resulting in lower sample sizes.

^{a,b,c}Means denoted with a superscript are significantly different from means denoted with a different superscript ($p < 0.05$, Bonferroni adjusted).

[†]Means adjusted for race.

*Wilks's Lambda F -test from MANOVA.

**MANOVA requires complete data for all variables; missing data result in lower sample sizes for all groups.

CRIMINAL BEHAVIOR

Elliot, Huizinga, and Ageton's (1985) Self-Reported Delinquency Measure (SRD) was used to assess delinquency. The scale has 32 questions using a 7-point frequency scale from 0 (*never*) to 7 (*2–3 times per day*) on questions ranging from drug use to aggression. The instrument has several subscales including alcohol use, drug use, felony assault, felony theft, general delinquency, property damage, public disorderly, robbery, and selling drugs. These subscales had acceptable interitem reliability (see Table 3), ranging from .69 for general delinquency to .88 for felony theft; drug use ($\alpha = .46$) and public disorderly ($\alpha = .52$) were the exceptions and both were dropped from further analyses.

RESULTS

In order to reduce the likelihood of Type I error inflation, multivariate tests (MANOVA) were conducted on the five trauma variables on the CTQ, the 11 scales on the MACI, and the 7 SRD scales between the sexually victimized, nonsexually victimized, and general delinquency groups, including

TABLE 2 Results of MANOVA for the MACI Subscales[†]

Variables	Cronbach's α	Mean (SE) Sexually Victimized <i>n</i> = 164***	Mean (SE) Nonsexually Victimized <i>n</i> = 130***	Mean (SE) General Delinquents <i>n</i> = 127***	<i>F</i> *	<i>DF</i>	<i>p</i> /effect sizes
MACI**					3.88	2,814	< 0.001/0.095
Introversive	.77	57.74 ^a (2.25)	47.74 ^b (2.43)	40.52 ^b (2.41)	13.96	2,417	<0.001/0.063
Inhibited	.78	61.42 ^a (2.41)	50.94 ^b (2.61)	39.75 ^c (2.59)	18.68	2,417	<0.001/0.082
Doleful	.83	66.42 ^a (2.56)	53.78 ^b (2.78)	39.98 ^c (2.75)	24.60	2,417	<0.001/0.106
Submissive	.73	53.63 ^a (1.47)	49.75 ^{ab} (1.60)	47.62 ^b (1.58)	4.07	2,417	0.018/0.019
Dramatizing	.77	48.79 ^a (1.77)	52.59 ^a (1.92)	50.34 ^a (1.90)	1.14	2,417	0.322/0.005
Egotistical	.75	45.88 ^a (1.54)	47.88 ^a (1.67)	48.39 ^a (1.66)	0.72	2,417	0.490/0.003
Unruly	.68	64.61 ^a (2.01)	63.72 ^a (2.18)	53.75 ^b (2.16)	7.82	2,417	<0.001/0.036
Conforming	.69	44.73 ^a (1.37)	45.35 ^a (1.49)	47.12 ^a (1.47)	0.73	2,417	0.484/0.003
Oppositional	.77	64.76 ^a (2.18)	59.53 ^a (2.36)	46.66 ^b (2.34)	16.61	2,417	<0.001/0.073
Borderline	.69	53.24 ^a (2.47)	47.33 ^a (2.68)	32.19 ^b (2.66)	17.21	2,417	<0.001/0.076
Tendency Self-Demeaning Tendency	.86	62.09 ^a (2.41)	50.41 ^b (2.62)	35.27 ^c (2.60)	28.29	2,417	<0.001/0.119

Note: Scales are presented as they are in the instrument. Casewise deletion of missing data was used resulting in lower sample sizes.

^{a,b,c}Means denoted with a superscript are significantly different from means denoted with a different superscript ($p < 0.05$, Bonferroni adjusted).

[†]Means adjusted for race.

**Wilks's Lambda *F*-test from MANOVA.

***The forceful subscale was dropped from the analysis due to low internal consistency.

***MANOVA requires complete data for all variables; missing data result in lower sample sizes for all groups.

TABLE 3 Results of MANOVA for the Self-Reported Delinquency (SRD) Subscales[†]

Variables	Cronbach's α	Mean (SE) Sexually Victimized <i>n</i> = 142***	Mean (SE) Nonsexually Victimized <i>n</i> = 118***	Mean (SE) General Delinquents <i>n</i> = 128***	DF	<i>F</i> *	<i>p</i> /effect size
SRD**					14,756	5.06	<0.001/0.086
Alcohol Use	.81	3.42 ^a (0.33)	2.90 ^a (0.35)	2.68 ^a (0.33)	2,384	1.30	0.275/0.007
Felony Assault	.65	2.66 ^a (0.25)	1.70 ^b (0.26)	1.01 ^b (0.24)	2,384	11.48	<0.001/0.056
Felony Theft	.88	6.16 ^a (0.54)	4.21 ^b (0.58)	3.45 ^b (0.54)	2,384	6.81	0.001/0.034
General Delinquency	.69	7.85 ^a (0.54)	5.50 ^b (0.58)	2.97 ^c (0.54)	2,384	20.21	<0.001/0.095
Property Damage	.74	3.69 ^a (0.31)	2.24 ^b (0.33)	0.94 ^c (0.31)	2,384	19.38	<0.001/0.092
Robbery	Not calculable— only one item	0.89 ^a (0.14)	0.77 ^a (0.15)	0.55 ^a (0.14)	2,384	1.57	0.209/0.008
Selling Drugs	.84	3.04 ^a (0.37)	2.88 ^a (0.40)	2.97 ^a (0.37)	2,384	0.05	0.954/<0.001

Note: Scales are presented alphabetically. Case-wise deletion of missing data was used resulting in lower sample sizes.

^{a,b,c}Means denoted with a superscript are significantly different from means denoted with a different superscript ($p < 0.05$, Bonferroni adjusted).
[†]Means adjusted for race.

*Wilks's Lambda *F*-test from MANOVA.

**The drug use and public disorderly subscales were dropped due to low internal consistency.

***MANOVA requires complete data for all variables; missing data result in lower sample sizes for all groups.

race as a variable. In addition, we reported the results of the individual variable *F* tests from the MANOVA that were conducted in order to determine which of the individual CTQ, MACI, and SRD subscales were significantly different between the sexually victimized, nonsexually victimized, and general delinquency groups (see Tables 1, 2, and 3). The rationale for using MANOVA is to avoid potential multicollinearity between the measures. Since the measures as a whole were significant in the analyses, it is usually the case that one would investigate whether all individual scales were significant or just some of them. Finally, we adjusted all means for race.

Developmental Antecedents

On the physical and emotional abuse subscales of the CTQ, all three groups were different from one another (see Table 1). The victimized juvenile sexual offenders reported experiencing significantly greater levels of all five types of abuse than the other two groups. This validates the subgrouping method and was expected. On three of the subscales, the general delinquents were not significantly different from nonsexually victimized juvenile sexual abusers.

On eight subscales of the MACI, there were significant differences between the groups with all *p* values < 0.001. On four of the subscales, the three groups were all significantly different from one another: introversive, inhibited, doleful, and self-demeaning tendency. Where there were significant differences, in all cases the general delinquents had the lowest mean scores while the sexually victimized juvenile sexual abusers had the highest. For example, on the self-demeaning tendency scale, the victimized juvenile sexual offenders averaged 63.84, the nonvictimized juvenile sexual offenders averaged 51.00, and the general delinquents averaged 34.88 (see Table 2). On three of 11 subscales (dramatizing, egotistical, and conforming), there were no differences among the three groups.

There were two analyses, involving the unruly and oppositional scales, in which the general delinquents were significantly different from the other two groups. On the submissive scale, the sexually victimized juvenile sexual offenders were significantly different from the general delinquents. It was the only subscale where the nonvictimized juvenile sexual offenders had scores that were not significantly different from either of the other two groups.

Behavior

On the SRD, the general delinquents had the lowest general delinquency score compared to the other two groups, but the highest scores on the selling drugs scale (see Table 3). On two subscales (general delinquency and property damage), all three groups were significantly different from one another. Regarding the remaining two scales, felony assault and felony

theft, the general delinquent youth were not significantly different from the nonsexually victimized juvenile sexual offenders, while those two groups were significantly different from the sexually victimized juvenile sexual offenders. On the seven subscales of the SRD that were used in the analysis, there were no significant differences between the groups on three of them.

DISCUSSION

Burton, Duty, and Leibowitz (2011) offered a full discussion regarding the differences between the sexual offender groups; we will therefore restrict this discussion to differences between the two juvenile sex offender groups and the general delinquency group and new findings. In terms of research implications in the earlier study, it was suggested that nonvictimized abusers be compared with delinquent adolescents to determine if these groups are similar in terms of pathways to aggression (coinciding with the typological research) and treatment needs. In 20 out of the 23 analyses (87%) in the present study, the scale means followed the same pattern: sexually victimized youth had the “worst” results (highest scale scores), followed by nonsexually victimized sexual offenders and general delinquent youth. That is to say, general delinquent youth had fewer behavioral and development problems than victimized and nonvictimized juvenile sexual offenders. This differs from previous research findings on this issue (as summarized by Seto & Lalumière’s, 2010 meta-analysis). However, given the present study had a larger sample size than many of these previous studies and included continuous measures rather than dichotomous or reduced measures (which are needed for meta-analyses, as measures have to be reduced across studies to create a common denominator), it might be expected that we would indeed find clearer differences between groups.

While the means of the scale items followed the pattern described, in terms of probability this was not so much the case. As indicated in the tables, on seven scales the three groups significantly differed from each other (CTQ: emotional abuse and physical abuse; MACI: inhibited, doleful, and self-demeaning tendency; SRD: general delinquency and property damage). On six of the scales, the three groups were the same (MACI: dramatizing, egotistical, and conforming; SRD: alcohol use, robbery, and selling Drugs). On five of the scales, nonsexually victimized sexual offenders and general delinquents were significantly different from sexually victimized sexual offenders (CTQ: emotional neglect, physical neglect, and sexual abuse; MACI: submissive; SRD: felony assault and felony theft), while on four of the scales sexually aggressive youth as a whole were significantly different from general delinquents but not from one another (MACI: submissive, egotistical, oppositional, and borderline tendency).

There are many interesting points for discussion that emerge from these patterns. For example, on three of the five CTQ trauma scales, the nonsexually victimized and general delinquent groups held together (i.e., the means were not significantly different from one another). Perhaps traumatic sequelae were most severe for the sexual abusers who have been victimized (consistent with the extant literature on trauma among adolescent sexual offenders). Only on the MACI personality scales did the two sexually offending groups hold together (on 4 out of the 10 scales); perhaps the personality characteristics shared by the sexually victimized and nonsexually victimized groups were associated with the etiology or commission of sexually aggressive acts.

Finally, it is also interesting to consider the scales on which no differences between groups were found. Perhaps there was some overlap between the groups on variables in which the means were not distinctly different. In cases where there was plea bargaining and responses to legal sanctions (such as registration requirements) that resulted in reduced charges for a sexual offense, these findings regarding similarities may, in part, be due to judicial decisions rather than actual developmental or behavioral distinctions between the youth.¹ In terms of future research, we propose the missing fourth group (sexually victimized delinquents) needs to be included and even with this relatively large sample, larger and more generalizable samples would improve external validity.

Related to practice implications, by building on our previous research and adding a third group of delinquent youth, a clear delineation can be seen in this sample. These findings imply that different resource allocations and testing protocols may be needed for each of these groups of youth to address such issues as trauma, a history of sexual victimization, and other factors associated with sexual and nonsexual offending. These findings also suggest that recommendations regarding residential versus community placement decisions for these groups need to be carefully considered, as do changes in dosage of treatment and level of supervision and monitoring across these groups (see Table 4).

Finally, while Seto and Lalumière (2010) suggested modified multisystemic therapy for juvenile sexual offenders that include additional treatment areas that are not addressed in interventions designed for delinquent youth (e.g., addressing paraphilias), we also recommend other modalities addressing the specialized needs of victimized adolescent sexual abusers in offense-specific treatment, such as trauma-focused cognitive behavioral therapy (e.g., see Cohen, Mannarino, Zhitova, & Capone, 2003). In agreement with previous research, trauma is a strong and salient variable in understanding the differences between these groups (e.g., Seto & Lalumière; van Wijk et al., 2006). Further research on the impact of traumatic stress on these groups of adolescents is warranted, which is integral to the prevention and treatment of adolescent sexual abuse.

TABLE 4 Differential Resource Allocation by Group

	Sexually Victimized Sexual Offenders	Nonsexually Victimized Offenders	General Delinquents
Assessment	Highest (e.g., deviant sexual interests, trauma, personality, and nonsexual criminality)	Moderate testing protocols	Fewest testing protocols
Trauma Informed Treatment	Highest	Moderate	Lowest
Placement (based on risk and needs)	More likely to need residential	Residential and community	Community and residential
Treatment Dosage (e.g., number of sessions)	Highest	Moderate	Lowest
Supervision	Highest	Moderate	Lowest
Monitoring	Highest	Moderate	Lowest

Limitations

There are limitations with all studies utilizing self-report data. However, we did remove data from the analysis based on social desirability criteria indicated on the MACI scoring rules. In addition, findings may not generalize to nonincarcerated males or community-based samples. Similarly, as a nonprobability sample, external validity is limited. Finally, the inclusion of a comparison group of sexually victimized general delinquents would have made the results even more robust.

NOTE

1. The distinction between the sexual offender and the nonsexual offender groups was determined by facility location based on legal charges.

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Preventing sexually abused young people from becoming abusers, and treating the victimization experiences of young people who offend sexually☆

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Abstract

Objective: This study was designed to determine whether it is possible to prevent those sexually abused boys who are at risk of abusing other children from doing so, and to assess whether factors associated with an experience of sexual abuse in young people who are offending can be dealt with as a key aspect of therapeutic work alongside treatment of offending behavior.

Method: The author examined cross-sectional and longitudinal research which demonstrates the impact on sexually abused children of living in a climate of violence, suffering physical abuse, exposure to abuse of maternal figures, and suffering disruption and poor quality of care and supervision. These factors are confirmed in prospective research.

Results: The application of these findings to therapeutic programs for boys who are sexually abused is described, including the assessment of care needs as well as the specific therapeutic work with the young person, and work to modify the family context. The specific treatment of victimization experiences in young people who have committed sexual offenses is also examined, with recommendations for modification of treatment approaches suggested.

Conclusion: It is vital in therapeutic work with boy victims of sexual abuse that the issue of their abusive potential be considered, even if a relatively small proportion of such boys will go on to abuse others. Given that boys who do sexually abuse are likely to have grown up in a climate of violence and poor care, methods of dealing with such victimization experiences need to be developed alongside offending focused treatments. © 2002 Elsevier Science Ltd. All rights reserved.

Keywords: Prevention of sexual abusive behavior; Treatment of victimization experiences of offenders

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Introduction

Sexual abuse itself is one of the most common forms of child abuse. The majority of children who are sexually abused are females, but generally sex offenders are male. Although there is considerable emphasis on prevention through education programs aimed at teaching children self-protection skills, it would also seem to make more sense to focus prevention strategies on those who perpetrate abuse, that is, on the approximately 30% of young people and the 70% of adult males responsible for abusive behavior.

There has been a considerable growth in treatment services for both adolescent and adult perpetrators. Offender-focused approaches to child protection ensure that those responsible for child protection services are becoming aware of the way in which offenders target, groom, and abuse children, and organize professionals to minimize and doubt the testimony of the children they have abused. Treatment services for those responsible for sexual offenses are therefore an important preventative strategy.

Another preventative strand is to focus on the fact that sexual abuse seems to be a prominent factor in the lives of those young people and adults who do go on to abuse sexually. Reviews (e.g., Bagley, Wood, & Young, 1994; Seghorn, Prentky, & Boucher, 1987; Watkins & Bentovim, 2000) have indicated that sexual abuse may be an important risk factor among a number of other abusive experiences which may influence a boy to develop an orientation which is abusive to other children, both in adolescence and in adult life. It would therefore seem a sensible strategy to identify those boys who are at risk and to provide an appropriate intervention to prevent future abusive action. This article will summarize cross-sectional and prospective research that examines the factors that influence boys who have been sexually abused to abuse others, and will suggest a tentative program of work to achieve preventative goals. It will be noted that exposure to a pervasive atmosphere of violence in the home is a key factor associated with the development of abusive behavior. The implications for the treatment of sexually abused children will be explored with this in mind. This article will also address the issue of what ought to be the therapeutic focus for young people who have begun a career of abuse. Within offender treatment approaches, there is a proper focus on the need to confront the offending behavior of young people. However, there is a growing awareness that early experiences and attachment style has a major influence on offending behavior and needs to be a focus to help achieve an abuse free life, that is, young offenders may still be living in contexts of considerable stress and victimization at the time their perpetrating behavior is discovered. There needs to be a focus on such victimization experiences as well as offending behavior in their treatment.

Thus, the theme of this article focuses on the necessity of working with the extensive victimization experiences of children and young people at the time when children and young people are identified as having been sexually abused. When young people are identified as being responsible for perpetrating sexual abuse against others, as well as their offending patterns being worked with, it is also essential to assess and intervene with their victimization experiences.

Review of research on factors which influence victims of sexual abuse to become perpetrators

Finkelhor (1986) has argued cogently about the dangers of a single factor theory whereby victims of sexual abuse are expected in turn to become victimizers. He is concerned that such a notion could become a self-fulfilling prophesy. Kaufman and Zigler (1987) have warned of the impact of experimental design on the perceptions of the strength of association. They cite a study of physical abuse and neglect where retrospective analysis indicated a 60% rate of intergenerational transmission, while prospective analysis indicated a rate of only 18%.

At the same time, victim to abuser cycle has been noted to be relevant in those working with adolescent offenders. Becker (1998), in reviewing current knowledge of sex offending adolescents, noted that adolescent sex offenders reported more histories of maltreatment, both physical and sexual, compared to generally conduct-disordered young people. Findings with adult sex offenders again compliment what is described with young people. Rates vary considerably from study to study. Groth and Burgess (1979) reported 32% of their sample of child molesters had reported some form of sexual trauma. Briggs (1995) reported 93%, Faller (1988) 27%, Graham (1996) 70%, Pithers, Kashima, Cumming, and Beal (1988) 56%. Freeman-Longo (1986) argued that abuse involving multiple abusers or repeated abuse of long duration is more influential, indicating that it was not just the fact of abuse itself that was of relevance. Therefore, it would seem that the sexual abuse of boys in childhood may be an important contributory, but not a necessary, factor in the development of perpetrating behavior. Langevim, Wright, and Handy (1989) noted that only a small fraction (16%) of their series had experienced extensive sexual abuse, but noted that a disorganized and aggressive home made them more vulnerable to sexual experiences outside their homes, one of which was sexual abuse.

There is also an increasing focus prospectively on the connection between childhood maltreatment and subsequent offending behavior (Rivera & Widom, 1990; Widom, 1989; Widom & Ames, 1994). There are a number of suggestions about how maltreatment connects with such behavior. Farrington (1991) highlighted the fact that a variety of adverse experiences, such as poverty, poor parental childrearing, and family criminality, predisposed to offending behavior, while Patterson, DeBaryshe, and Ramsey (1989) adopt a developmental approach noting the links between poor parenting, antisocial behavior, academic failure, rejection, association with deviant peers, and the subsequent initiation of offending behavior. This model was supported in Falshaw and Browne's (1997) study of the adverse childhood experiences of young people who subsequently perform such violent acts that they are placed in secure accommodation.

Research at Great Ormond Street and the Institute of Child Health

Cross-sectional and longitudinal exploration of the factors that lead to the onset of sexually abusive behavior in males who are sexually abused in childhood

Cross-sectional study

This took the form of an intensive, hypothesis generating study on a relatively small number of young people (Skuse et al., 1998). A series of young people and their families were studied intensively. There were four groups recruited including:

1. Boys between 11 years and 16 years who had been victims of sexual abuse, who showed no evidence of perpetrating abuse against others;
2. Boys who had been victims of sexual abuse who were showing evidence of having begun to perpetrate against other children;
3. A group of boys with no evidence of sexual abuse but who nevertheless were offending sexually against other children; and
4. A group of young people who were showing antisocial behavioral problems but with no evidence of sexual abuse in their history, nor of abusing sexually against others.

Therefore, it was possible to carry out a variety of assessments on each group of these young people, to understand the specific factors which increased the risk of a young person who had been abused in childhood beginning to offend against other children. A total of 78 boys were referred to the study, 32 of whom had abused other children and young people.

In the first stage of the assessment, information was collected on intelligence, behavior, pubertal status, socioeconomic circumstances, and friendships. A socio-metric study was carried out in the schools the young people attended to understand peers' perceptions of the boys. The second stage consisted of 3 months of individual weekly psychoanalytic psychotherapy. Sessions were conducted by a child psychotherapist, semistructured using a variety of standardized instruments including measures of attachment and hostility. Subsequent responses were analyzed using a grounded theory approach to derive childhood themes relating to the history of care and maltreatment. Less structured sessions covered the boys' life histories, their patterns of sexually abusive behavior, and sexual fantasies. These were verified from independent sources. Birth mothers were interviewed about their own life history, their experience of maltreatment, and aspects of family life.

It was therefore possible to carry out a variety of comparisons and derive hypotheses to assist in understanding the processes that could contribute to offending behavior.

Important factors emerged from the analyses. There were no differences found between the groups who suffered abuse in terms of their experience of sexual victimization, based on personal accounts and contemporaneous records. Severity of abuse was ascertained from evidence of penetration, whether there were a number of perpetrators involved or whether abuse was within or outside the family. This lack of difference was unexpected because earlier work (Hyde, Bentovim, & Monck, 1995) indicated that those boys who went on to abuse others appeared to have been more severely abused over longer periods by a number of perpetrators. The numbers assessed were small, however, and there may have been a referral bias. However, selecting young people to intervene on the basis of more serious abuse may not be the sole factor in terms of preventing the development of offending behavior.

A number of other factors were looked at which seemed to be relevant during the assessment process. These included:

- Experiencing intrafamilial violence;
- Witnessing intrafamilial violence;
- Rejection by the family;
- Discontinuity of care;
- Rejection by peers;

- Experiencing a generalized sense of grievance;
- Poor identification with father figures;
- Absence of a nonabusive male attachment figure;
- Having a mother who was sexually abused in childhood;
- Maternal depression;
- Poor sibling relationships;
- Having a mother who was physically abused in childhood; and
- Low levels of guilt concerning abusive action.

Many of these were factors that emerged when working with young people who had abused sexually. In this cross-sectional study the most significant factors, however, were those relating to experiencing intrafamilial violence, witnessing intrafamilial violence, and experiencing care rejection.

These experiences preceded the sexually abusive behavior that led to referral. We understood that what differentiated this group was “living in a climate of intrafamilial violence,” which may or may not have directly involved the boys as a victim. It was felt that discontinuity of care and rejection amplified the effects of witnessing and being subject to violence.

There were similarities in the lives of boys who abused sexually but who had no history of sexual abuse themselves. They grew up in a family context where they were exposed to a climate of violence in the home. In addition, their mothers had themselves been subject to extensive sexual and physical abuse not only in their own childhood, but in adult life. These boys were exposed not only to a climate of physical violence, but also a sexual violence which may have had a similar effect to being sexually abused themselves.

Although this cross-sectional study could not look at mechanisms, we hypothesized that experiencing physical violence directly or being exposed to a climate of violence subjects a child to prolonged fear and stress, often for long periods of childhood development. This will adversely affect key developmental tasks and personality development through early childhood, middle childhood, adolescence, and adult life (Pynoos, Sorensen, & Steinberg, 1993).

Discontinuity of care, living in turn with various parents and step-parents, or being in local authority care could lead to a profound feeling of rejection. This had a bearing on the formation of attachments, and may result in the lack of a secure relationship with an adult. Severe, unpredictable stresses have links with psychopathology in both adolescence and adulthood. We felt that these boys were having the worst of both worlds, suffering both disruption of care and violence. They were missing confiding relationships that could have protective effects.

We also felt that directly traumatic and traumagenic effects of pervasive violence led to subjected helplessness, the evacuation of defensive aggressive fantasies, and traumatic visualization of abusive experiences (Bentovim, 1995). Later sexualization of aggressive fantasies led to the “eroticization” of aggression, which leads in turn to abusive behavior. We felt that such aggressive behavior may well be a fight response, taking the form of revenge fantasies acted out in adolescence to reverse a sense of powerlessness, and project such feelings on other young people as a way of feeling less burdened themselves. This was a detailed study on small numbers, and findings must be treated with caution.

Prospective study

These findings were further tested in a prospective manner (Skuse et al., 1999). All males referred to Great Ormond Street under the author's care for reasons relating to sexual abuse from 1980 to 1992 were studied (224 male subjects). Demographic data and information about sexual victimization of the sample was collected from clinic and Social Services files when these were available. Evidence of the development of offending behavior was obtained by further scrutiny of Social Services files when they were available in the years that followed original victimization. In addition, criminal record data were studied from a range of sources, national police conviction records, and local police caution records to ascertain which of the young people had gone on to abuse.

We were therefore able to address the following questions:

- What proportion of sexually victimized subjects would become sexual perpetrators in later life?
- What is the risk of victims becoming offenders?
- What proportion of such victims are dealt with subsequently through criminal procedures?
- What proportion of those individuals who perpetrated during adolescence continue to offend in later life?
- What experiences would increase the risk of a sexually victimized young person becoming a perpetrator, and what experiences would decrease this risk? and
- Which risk factors should alert professionals to the danger of a young person going on to abuse others, and which factors can be brought into play to prevent this process occurring?

Young people who had been abused sexually were investigated intensively by both Social Services Department and at Great Ormond Street, who referred young people for treatment. There was considerable information available that shed light on any subsequent perpetration, which became evident through tracking the young person's subsequent history. In general terms, the study confirmed that the originally defined risk factors from the cross-sectional studies were supported by the prospective study. Detailed results will be reported shortly.

It is also important to draw attention to the impact for boys living in a context of neglect and pervasive violence perpetrated against maternal figures, who may not have themselves been sexually abused. There may be an increased risk for these boys of perpetrating themselves, which needs to be kept in mind when working with such young people.

Implications for practice to reduce the risk of victims of sexual abuse becoming perpetrators

To avoid the development of perpetrating behavior, it is necessary to develop appropriate intervention strategies:

- At the time when abuse has been disclosed;
- During the phase of work when the child or young person is protected from abuse;

- Careful consideration needs to be given about rehabilitation of children abused within their family context to their family; and
- Alternative family placements need to be found for those children who will continue to be exposed to a climate of violence, neglect, and rejection.

It seems likely from the work of Saradjian (1996) that female abusers may well share many of the factors which lead to the abusive pattern shown by boys. There is a lesser likelihood of girls becoming abusers, and many of the factors which lead to explosive violent behavior on the part of boys may well lead to explosive violent behavior against themselves, noted in girls who are self-mutilating, or show anorectic or self-harming patterns of behavior. Boys may also show similar patterns.

Preventing victims developing offending behavior

Work during the phase of disclosure that sexual abuse has occurred in boys

Disclosure that sexual abuse has occurred always evokes an intense crisis because of the effect of breaking the web of secrecy and silencing. The Descriptive and Treatment Outcome Research at Great Ormond Street demonstrated that denial that abuse had occurred was the most frequent response by perpetrators in a series of 99 children. Only a small proportion (9% of abusers) took full responsibility for their actions. Fifteen percent took some responsibility, while the largest proportion (74%) continued to state they were not responsible, accusing the child of lying or professionals for constructing abuse falsely (Hyde, Bentovim, & Monck, 1995; Monck et al., 1996).

Watkins and Bentovim (2000) noted the difficulties for boys in being able to state they had been abused at all. Boys are more likely to be abused outside the family, and there may well be denial on the part of boys because of fears that their freedom will be restricted if they report abuse. In addition, boys often experience intense fears that abuse occurred because their abuser has perceived something “homosexual” in their bearing, which led to them being picked out. Therefore, considerable denial on the part of boy victims is a common factor, as well as denial by abusers.

The Great Ormond Street research showed that frequently maternal responses fitted in with the father’s perception. Thirty-six percent of mothers were perceived as negative and disbelieving, while only 44% supported the child unequivocally. By the time the children were referred for therapeutic work, it was not surprising that 60% of the children were living in alternative contexts, and a third of children continued to be disbelieved by both parents by the time the children were referred for treatment. Children’s mental health as measured by levels of anxiety, depressive symptoms, post-traumatic symptoms, and self-esteem was influenced in part by the extensiveness of abuse, but was also significantly related to whether the child was believed and supported by their mother, or whether they were criticized and therefore felt a negative sense of esteem. Younger children were more likely to be believed and supported than if the victims were older.

Therefore, it is essential during this phase of disclosure to ensure that there is an

assessment of the extent of abuse, its nature, length, severity, extensiveness, and who is responsible. This work often takes a period of time to overcome the reluctance, anxiety and denial, and fear of consequences of disclosure, particularly with boys.

An assessment of the family context is essential to ascertain the pattern of risk versus protection. Exposure of the child or the young person to physical violence, domestic violence, a history of abuse perpetrated against parents (particularly the mother), the presence of neglect, failure of supervision, and the absence of nonabusive carers within the family context are all essential aspects of the initial assessment following disclosure. The assessment also needs to find out whether protective factors are present, such as in the research, positive relationships with adults, siblings, peers, and the quality of alternative care.

To assess the risk of abusive behavior occurring, it is necessary to explore the development implication of victimization behavior on basic functioning—the regulation of emotional life of the child, attachment style, and sense of self. Of particular concern are emotional responses that are externalizing rather than internalizing.

Externalizing responses in the emotional life of the young person include hyperarousal, intrusive actions, violent fantasies, explosive outbursts, and the development of an intimidating, frightening style, anger and grievance, sexualization of closeness, and sexual aggression (Thomas, 1995).

There is also concern if attachments are dismissive, indiscriminate, controlling, or disorganized in form. The sense of self may well be affected if there is a fragmented sense of self, identification with the aggressor, and evidence of early imposition of sexual and aggressive behavior on others, a blaming punitive style, or an aggressive bullying style of relating (Cicchetti & Toth, 1994).

These patterns are all indicative of a style that is potentially dangerous, threatening, and evidence that the child or young person is possibly moving from a victim to a perpetrator mode.

Decisions about care in the context of initial assessments, potential for change

Research on factors which are associated with abusive action focus on the climate of family violence and the need to ensure the abused child lives in a supportive context. The decision about care depends on the prognosis for change within the family context, the extensiveness of the needs of children and their timeframe, and the capacities of the parents to acknowledge their role in direct or cumulative family violence effects and the potential for change. Using the framework developed to assess prognosis (Silvester, Bentovim, Stratton, & Hanks, 1995), we find the following classifications helpful.

Hopeful prognosis

It is possible to make a hopeful prognosis and to maintain children within the family context if family members acknowledge their roles and responsibilities; an abusive parent accepts that he or she needs to live separately to seek help in their own right; protective parents are firm in their belief that the child has been abused and are able to maintain the

relationship with the child, despite the pressure brought against them by an abusive partner; the child is not blamed for having spoken; the parents are willing to work on personal and family issues, to confront personal experiences of violence, to deal with past and present domestic violence to which children have been exposed, and to demonstrate a capacity to work with professionals.

Doubtful prognosis

These are situations where it seems necessary to use the care process because there is far more uncertainty about outcome, doubt about the capacities of parents to work with professionals, or to achieve positive outcome within the child's timeframe.

In these situations, there is often a high level of uncertainty whether the child or adult is responsible for the state of the child, or the child is tentative, unsure of support from caretakers. There may be a limited perception for the need to change on individual or marital basis, or a degree of uncertainty about the capacity of the parent to be able to change, to manage to extricate themselves from a seriously violent relationship. There may be a pervasive multigeneration pattern of abuse or addiction/alcoholism that seems extremely difficult to confront or to change. These are situations of considerable doubt, and statutory proceedings may be required to test the parents' capacity to reverse seriously abusive contexts.

Hopeless prognosis

These are situations where there is an absolute failure to acknowledge the child's state, his or her statements of abuse are absolutely rejected, or it is imputed that the professional has been putting ideas in the child's mind.

Whatever the context that children are living in, depending on their needs for care, it is essential that an appropriate treatment is developed, particularly for those children who have been exposed to high risk contexts and have had few protective factors in their living situation.

Treatment and protection in a context of safety

Once the initial assessment has been carried through with a decision made about where child should live and with whom, it then becomes essential to work during the context of safety to reverse the effects of abuse. Providing a positive context of care is the essential first step, and any therapeutic work that does not have a background of adequate care is likely to be ineffective. Therapeutic work cannot be a substitute for good care but can only facilitate the process.

Therapeutic work to reduce offending potential

Repair of attachments

Disruptive, disorganized attachments that result from living in a climate of violence and abuse need work not only in the family context, providing a "re-parenting" experience, but

in individual and group therapeutic contexts. It is essential that individual work with children and young people who have been abused focus on building a positive attachment between the therapist and the child as one of the elements to repair avoidant, or disorganized attachments (Freidrich, Luecke, Beilke, & Place, 1992). There needs to be the fostering of acceptance between the therapist and the child and sensitivity to the attachment style of the child, rather than expecting a uniform response. There should be a reasonable degree of warmth and responsiveness, but not too intense; otherwise the child may be reminded of an abusive context that groomed him or her to accept inappropriate sexual activity. Therapeutic work needs to be rewarding, developing relatedness, finding solutions in a collaborative fashion. A working alliance needs to be created which develops connectedness and availability and safety, a considerable challenge for young people showing a dismissive, disorganized pattern that tests therapists' capacity to maintain an alliance.

Group work can help a young person gain a sense of belonging and identity, and to find a healing "family" context in a group with other young people and therapists, preferably of both sexes. There needs to be the fostering of boundaries, safety, and confronting the re-enactment of abusive models occurring between group members and the therapists, with constant confrontation and finding alternative ways of relating.

Work needs to take place between family members who accept that abuse has occurred in the child in the first instance. The possibility of family work including the perpetrator can be considered at a later date to foster understanding of what led to abusive action and the intergenerational effects that may be re-enacted. Small or rapid treatment gains are necessary using activities to enhance shared affiliation, pleasure, and achievement.

Management of emotional dysregulation

The essential core of helping children and young people regulate their emotions is through the sharing of abusive experiences, so that the emotional negative impacts of abuse and externalizing responses and post-traumatic stress symptoms can be exposed and processed (Deblinger, Lippman, & Steer, 1996). It is essential to explain that the aim is to reduce anxiety, that children are given training in coping skills and in the expression of emotion by developing a vocabulary for emotions, identifying their own and others' emotions, coping with anger/arousal/anxiety, being able to describe emotions associated with abuse, and to develop relaxation skills.

It is essential that coping strategies are developed before there is exposure and attempts to describe the extensiveness of abusive experiences. Cognitive behavioral approaches (Deblinger, Steer, & Lippmann, 1999; Finkelhor & Berliner, 1995; Jones & Ramchandri, 1999) have been demonstrated as being highly effective approaches to dealing with emotional dysregulation. It is important for the child to find ways of being able to deal with re-enactment, visualizations, explosive feelings, and responses. The use of play, creative productions in vivo visiting contexts, and visualization of episodes are all methods of exposing and sharing. There needs to be considerable care in how experiences are shared: limiting the amount shared in each session; structuring sessions to limit exposure time; using creative psychoeducational approaches, diagrams, pictures charts, and games as ways of separating the experience from self during the process of working through; and reducing

emotional arousal. Collaborative/problem solving/solution-focused approaches to the work is essential with careful monitoring of responses, particularly with boys who are showing extensive externalizing behavior.

Protective parents require coping skills training themselves, identifying their own feelings related to the abuse of their child, and then gradually being exposed to a discussion of their children's experiences and activities. They need to enter discussions about sex education, personal safety, and coping with post-traumatic symptoms, sexualized behavior, and emotional outbursts. Group and family work can reinforce ways of sharing, particularly by children of similar ages and stages of development (Bentovim, Elton, Hildebrand, Tranter, & Vizard, 1988; Hyde et al., 1995).

Developing a positive sense of self

The treatment aims of helping children and young people develop a positive sense of self which will prevent the victim-offender cycle includes developing a correct attribution for events, creating a healing alternative story, and becoming safe from retraumatization and the abuse of others.

Both individual and group work approaches need to confront the cognitive/affective processes evoked by abuse. Adequate motivation is required to explore and understand the attributions of self-blame, guilt and responsibility for having been vulnerable, for having allowed oneself to be targeted and groomed into abusive activities. There needs to be the development of a cognitive skill to dispute the nature and origin of beliefs that blame the self rather than the other (Deblinger et al., 1996). An alternative healing belief story needs to develop. What may seem to be frightening—flashbacks, intense angry outbursts, abusive revenge, and fantasies—are connoted as pathways to autonomy and strength, turning powerlessness to power. Even though they may appear to be dangerous, at the same time they need to be seen as part of a healing process.

There needs to be extensive explanation given for the process by which the child or young person has become abused, the silencing and rationalization used to entrap and silence. Sexual feelings evoked and beliefs need to be corrected. There needs to be openness and acceptance of all communications, and a full history of experiences obtained including victimization and victimizing experiences. Boys who are in the process of becoming offenders find their sexual lives filled with confusing images of themselves, their abuser, and feelings about other children which create a considerable sense of shame and guilt. An assumptive therapeutic style which names such processes with familiarity and comfort will enable boys to share their extremely uncomfortable experiences.

Dysfunctional thoughts about body image, body change, and gender orientation is also an essential accompaniment of such experiences. One of the common defensive processes, for instance, which boys have described is imagining that heterosexual activities were going on when they were being abused by a male. When confronted with who is the female partner this often helps gain an understanding of why boys may feel confused about their identity, about their bodies, about themselves, whether they are homosexual, and whether they have abnormal sexual feelings.

There needs to be work with guilt and responsibility concerning the inevitable sexual

arousal that needs careful explanation. Education about healthy sexuality, gender, and the law is necessary. Young people need to understand the process of healthy and unhealthy cycles of relationships. The notion of a dating cycle which helps young people learn how relationships are made with peers can be helpful in contrast to an abusive cycle which may very well be part of the developing offending behavior, including fantasies, masturbatory activities including their own abuse and abuse of others, and a sense of grievance. They need to understand that it is possible to blame young people who evoke sexual arousal in themselves, rather than own responsibility and take control of their own actions and response. This phase of work is particularly relevant when working with young people who themselves are at risk of developing abusive patterns of behavior as noted. In our original cross-sectional study, young people were seen who were beginning to show some signs of the transition to abusive patterns of behavior.

It becomes essential to develop personal safety skills, notions of ownership boundaries, and safe space to deal with powerlessness in a more effective way, without using aggressive or intimidating behavioral approaches, to understand the link between powerlessness, grievance, and revenge. It is essential to identify potentially dangerous situations and to recognize the justification/distortions of thinking that confuses sexuality and affection, interrupting and challenging such cycles, and to find safe ways of finding support within the community. Such issues need to be tracked within groups and family contexts, particularly when a family member has been able to acknowledge abusive action, take part in appropriate therapeutic work, and take responsibility and truly apologize to the victim of abuse.

Stage of rehabilitation to family life

To their own families

The ideal is for children who have been abused to be able to be restored to their own family, for the relationship with their caring parent to be strengthened. Where abusive family members can take responsibility, there should be thorough work on reversing abusive patterns, and a process of apology, reconciliation, and understanding of processes which led to violent behaviors, freeing the victim of a sense of guilt and grievance, and considering the possibility of rehabilitation of the abuser to the family. A number of areas need to be worked with in families.

Working on a climate of violence—exposure and experience of physical abuse

A key factor that leads to the promotion of an offending behavior is the exposure to physical violence and neglect. In this phase of assessment, the possibility of therapeutic work with families focused on this issue needs to be evaluated. Where there is acknowledgment of such factors, then involving the family either as a whole or in parallel work with the young person and the family needs to be considered. As far as approaches are concerned, Kolko (1996) contrasted cognitive behavioral treatment with family therapy against a community care control group. Both therapeutic approaches were more successful than control in

reducing parental violence towards children, and reducing children's externalizing/aggressive behavior lessened the transmission of an aggressive style, improved family cohesion, and reduced conflicts. A multisystemic approach (Henggeler, 1999) also stresses the need for collaborative work with all family members, the utilization of evidence-based approaches, and an active approach which can demonstrate tangible gains.

Specific work with the family that can reduce the risk of offending behavior includes (Monck et al., 1996):

- Extensive work on clarifying exactly what abusive action has been perpetrated, by whom, attempting to ensure that full responsibility is taken, blame reduced, and appropriate apologies given;
- Constant work on denial, minimization, and projection of blame so that children who are abused do not take on inappropriate responsibility with a sense of guilt and perpetuation of externalizing responses;
- The issue of power, powerlessness, and appropriate empowerment needs to be constantly focused on within the family context to redress the inappropriate use of power; appropriate assertion should replace intimidation;
- Blurred and confused role boundaries need to be corrected so that inappropriate role modeling and identification with the aggressor is not amplified within the family context; and
- Loss and bereavement is appropriately focused on to assist young people who cannot live with their families of origin to deal with the "identification with the aggressor," which is a process of dealing with such losses.

New families

A significant number of young children who are abused and living in a climate of violence, perhaps as many as 30%, will not be able to live with a family member because of the processes of denial and refusal to accept responsibility (Hyde et al., 1995). There are considerable difficulties for foster families and alternative placements caring adequately for children who have been extensively abused and who are at risk of re-enactment of abusive behavior within foster families. Residential care needs to be organized to provide alternative care for children who have been abused and to make intensive individual and group work available.

Work on the victimization experiences of those young people who have gone on to abuse other children

Given that victimization experiences play such an important role in the development of abusive behavior, it is essential that at all phases of work with young offenders consider the issue of their victimization experiences. The impact on their development and their behavior needs to be tracked, working with both the offending behavior and the experiences which

may be continuing to be a formative influence on their lives at the time when perpetrating behavior is disclosed.

Work during the phase of disclosure

It is essential during the phase of disclosure that a detailed assessment of actual patterns of offending behavior and of victimization experiences be made. Such instruments as the Trauma Symptom Inventory (Briere, 1995) are valuable tools to begin an evaluation of specific victimization experiences. As with all such measures, it is important to use the young person's responses as a way of beginning to address the issues and begin the processing of experiences.

Clinician-administered PTSD Scale for Children and Adolescents (CAPS-CA; Nader et al., 1996) is helpful as they invite a young person to indicate which events they have experienced from a list of traumatic events and then proceed to take each event and ask for specific evidence of post-traumatic effects, re-experiencing, avoidance, arousal, and general responses.

Decisions about care and management of a young person

Although the main task in assessing young people who abuse is to look at the issue of the degree of risk they pose to those who they have victimized in their own family or community, it is also essential to assess their requirement for protection because of the continuing influence of victimization they have experienced, such as exposure to violence perpetrated against maternal figures, continuing neglect, and poor supervision, as well as specific physical abuse. We were struck in our original hypothesis-generating study at the value of foster care for young perpetrators of living in supportive foster care, providing the general protective factors that we noted. Although not negating the high risk factors, this went some way to neutralizing them by providing nonabusive caretakers, particularly paternal figures, providing a model where maternal figures were not abused by paternal figures, a climate that was supportive rather than violent, and adequate supervision as well as material care. This provides a degree of re-parenting as an important general context for specific therapeutic work.

Treatment in a context of safety from further victimization, and prevention of ongoing victimizing behavior

The approaches that we noted in therapeutic work with victims are also relevant to the treatment of victimization experiences of those who are perpetrating. The important consideration is how the work with victimization fits into the overall therapeutic program of work on offending patterns of behavior. Practice has frequently focused on the requirement to understand the victim's perspective as a necessary stage to developing a relapse prevention program. This ignores the way victimization experiences can be extensively intertwined with offending impulses. These require clarification and attention at all stages of the therapeutic process: at the assessment stage, in establishing the pathway to abusive behavior and the cycle of abusive action, and developing an abusive-free life.

To address these issues requires the development of an extensive module of work if the implications of the research findings are to be adequately addressed. At the same time, there needs to be an awareness of the dynamic process of presentation of victimization issues as a way of avoiding confronting offending behavior.

Disorganized dismissive attachments present a constant challenge to resolving attachment issues, and developing a positive sense of self is a complex process. There needs to be exploration and understanding of attributions of self-blame for their own abuse and the way they have blamed their victims for evoking abusive impulses in themselves.

Stage of rehabilitation to families where abusive behavior has been perpetrated

Young people who have abused need to share the details of their abusing behavior with their families and to carry out appropriate apology sessions with victims. They also need to have acknowledged the extensiveness of their earlier abusive experiences as part of a rehabilitation process. Parallel work with families is required to address these issues if there is hopeful prognosis to work with such issues. Work with families is also essential for young people who cannot return to their families and who are being worked with in residential settings. This requires care and therapeutic structures to enable a young person to become safe in the community, safe to develop their own relationships in the future, and a caring approach to their own children, thus assisting in the comprehensive prevention of sexually abusive behavior in the community.

Concluding comments

When working with boys who have been sexually abused, it is important to assess whether, in addition to abuse, there is the additional presence of a pervasive atmosphere of violence in their home where a maternal figure is either victimizing or is extensively victimized, and where young people, as well as being sexually abused, are extensively neglected. These are the young people who are at risk of abusing, particularly if they are showing symptoms such as soiling and cruelty to animals. They require extensive help, both for their own experiences of abuse and to avoid future abusive behavior.

Those young people who have begun a career of abuse against other children require a program of work not only to deal with their own offending but also to explore their victimization experiences, to ensure that ongoing influences are addressed, the impact of such victimization experiences explored both in the way that offending behavior is triggered and perpetuated, and also in the way that such young people relate to those who care for them. Therapeutic work needs to address these issues as well as offending issues if a significant preventative impact is to be achieved.

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Résumé

Objectif: Déterminer s'il est possible d'intervenir pour que des garçons victimes d'agressions sexuelles et aptes à agresser d'autres enfants, ne s'adonnent pas à ces agressions; et aussi d'évaluer si les facteurs qu'on associe aux agressions sexuelles chez des jeunes agresseurs peuvent faire partie intégrante de la thérapie, de concert avec des interventions thérapeutiques ciblant le comportement agressif lui-même.

Méthode: Étudier les recherches longitudinales et latérales qui démontrent ce que représentent pour les enfants agressés sexuellement de vivre dans un climat de violence, d'endurer les mauvais traitements physiques, d'être exposés aux agressions des figures maternelles et d'endurer l'interruption et la mauvaise qualité des soins et de la surveillance. Les recherches prospectives confirment ces facteurs.

Résultats: L'article décrit la mise en exécution de ces constats par rapport aux program thérapeutiques ciblant les garçons agressés sexuellement. On évalue aussi les soins qui leurs sont nécessaires, les interventions thérapeutiques auprès de ces jeunes et les efforts pour modifier le milieu familial. Enfin, l'article considère les interventions thérapeutiques visant les agressions vécues par les jeunes victimes qui ont eux-mêmes agressé et recommandent des modifications à apporter vis-à-vis des approches thérapeutiques qui sont proposées.

Conclusions: Il est essentiel que les interventions thérapeutiques auprès de garçons victimes d'agressions sexuelles prennent en considération la possibilité que ces jeunes pourraient devenir des agresseurs, même si, de fait, ceci a lieu relativement peu souvent. Puisque les jeunes agresseurs ont probablement grandi dans un climat de violence, qu'ils ont bénéficié de peu de soins, on se doit d'élaborer des interventions qui visent leurs expériences en tant que victimes, de concert avec les interventions ciblant leurs comportements agressifs.

Resumen

Objetivo: Determinar si es posible evitar que los muchachos sexualmente abusados en riesgo de abusar otros niños, lleguen a hacerlo; y evaluar si los factores asociados con una experiencia de abuso sexual en personas jóvenes que están ofendiendo puede manejarse como un aspecto principal del trabajo terapéutico junto con el tratamiento de la conducta ofensiva.

Método: Examinar investigaciones transversales y longitudinales que demuestran la importancia que tiene para los niños sexualmente abusados el vivir en un clima de violencia, sufriendo abuso físico, expuestos al abuso de las figuras maternas, y sufriendo interrupción y pobreza en la calidad del cuidado y la supervisión. Estos factores son confirmados en investigaciones prospectivas.

Resultados: Se describe la aplicación de estos hallazgos a los programas terapéuticos para muchachos que han sido abusados sexualmente, incluyendo la evaluación de las necesidades de cuidado así como el trabajo terapéutico específico con el joven, y el trabajo para modificar el contexto familiar. Se examina también el tratamiento específico de las experiencias de victimización en personas jóvenes que han cometido ofensas sexuales y se sugieren recomendaciones para la modificación de los enfoques en el tratamiento.

Conclusión: Es de vital importancia en el trabajo terapéutico con muchachos víctimas de abuso sexual que se considere el tema de su potencial abusivo, aun cuando una proporción relativamente pequeña de estos muchachos se convertirán en abusadores de otros. Dado que para los muchachos que sí abusan sexualmente, es muy posible que hayan crecido en un clima de violencia y cuidados deficientes, es necesario desarrollar métodos para manejar estas experiencias de victimización junto con los tratamientos centralizados en la ofensa.

Profiles in the development of behavior disorders among youths with family maltreatment histories

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Violent conduct by youths ranks among the types of inappropriate behavior generally originating in difficult family and social contexts. A proper understanding of the development of violent conduct must consider the situation taken as a whole. This article documents the results of a qualitative study which aimed to determine the psychosocial profiles and needs of youths with serious behavior problems and a family history of physical, psychological or sexual abuse. The results are based on the review of clinical files of 12 boys and 11 girls between the ages of 9 and 17, who were under child protection. The 23 files were analyzed to document the simultaneous evolution of behavior problems, abuse, family and school context, and the intervention of child protection services (reporting, evaluation, measures taken, foster care). The qualitative analysis followed the chronology and life history of each youth, resulting in the emergence of three generic profiles: the Undesirable, the Explosive, and the Delinquent. Each of the profiles is described and placed in perspective using the attachment, trauma and socialization theories respectively. The study concludes with proposals of distinct intervention models to be applied to these youths in the school environment.

Keywords: *Behavior disorders; Child abuse and victimization; Childhood development; Intervention*

Social adaptation problems affect a large number of youths. In industrialized countries, between 5% and 10% of youths between 8 and 16 years old present persistent behavior problems (Hill, 2002). Consequently, violence in the school environment is a frequent, even routine occurrence worldwide (Debarbieux, 2003). In Canada, a survey conducted among a representative sample of 6259 children in the 6th, 8th and 10th grades revealed that 13.6% of the youths reported having bullied other youths, while 14.5% indicated having been victims of bullying during a school term (King *et al.*, 1999).

The etiology of behavior problems involves individual, family and social factors that interact during the child's development in accordance with complex and little-understood mechanisms (Hill, 2002; Reppucci *et al.*, 2002). Admittedly, the school

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has little control over some of the factors and mechanisms, particularly family adversity. However, the school can counterbalance the situation by offering a healthy relational climate, implementing violence prevention programs, and promoting social skills. It can offer compensatory services to youths in difficulty, in cooperation with other community organizations (Garbarino, 1987; Bowen *et al.*, 2001). The school can also contribute to the prevention of child abuse; through its social mission of education, it can stimulate citizens' social responsibility towards children and youths; and through its institutional practices, it can promote a positive ideology of the child (Hart, 1988).

However, interventions to prevent violence in school environments must be based on an unbiased, comprehensive understanding of the origins of inappropriate and violent conduct in youths and the ways in which such conduct develops. This study contributes to establishing specific psychosocial profiles of youths who, in addition to exhibiting serious behavior problems, also have a history of maltreatment, in order to establish distinct intervention means based on their specific needs.

Literature review

Children and youths' risk of undergoing various forms of victimization are numerous (Finkelhor & Dzuiba-Leatherman, 1994). A significant number of youths, mostly adolescent males, exhibit behavior problems such as aggressive or violent acts (Farrington & Loeber, 2000). D'Amours (1995) clearly illustrated the 'two sides to the coin of violence'. The metaphor is appropriate, because both problems are closely connected: children who are victims of violence, abuse or neglect are more likely than others to exhibit aggressiveness (Vissing *et al.*, 1991; McGee *et al.*, 1997). Following a review of literature on these connections, Jonson-Reid (1998) proposed a model where maltreatment and exposure to domestic violence should be viewed as factors contributing to violence among youths.

It is widely acknowledged that parental violence and neglect, sexual abuse and exposure to domestic violence are highly detrimental to child development (Cicchetti & Toth, 1995; Trickett & Putnam, 1998). Maltreated children tend to develop attachment and emotional adjustment problems. These in turn lead to difficulties in interpersonal relations and in school adaptation. The impact is particularly serious when different forms of victimization are juxtaposed during developmental phases, or when experienced repeatedly (Crittenden *et al.*, 1994; McGee *et al.*, 1997). Yet this appears to be the rule, rather than the exception, among youths from deleterious family and social backgrounds (Vissing *et al.*, 1991; Crittenden *et al.*, 1994; McGee *et al.*, 1997). In short, severely maltreated children stand higher chances of going through a chain of negative events, putting them at high risk of living a pattern of repeated failures, which includes marginalization and maladjustment, including the emergence of behavior problems. This pattern is a matter of great concern. Behavior problems that begin in early childhood are known to be the most stable in time, persisting into adulthood, which is indicative of their intractability to intervention (Dryfoos, 1990; Dobkin *et al.*, 1995).

Behavior problems develop gradually and the family may be viewed as the earliest setting for learning antisocial behavior (Reid *et al.*, 2002). In a dysfunctional family, a child may develop oppositional and coercive behavior and learn to exercise control over others. When the child enters school, this behavior may provoke conflicts with peers and translate into problems of opposition to authority, ultimately leading to social rejection and school failure. Such youths may then gravitate towards groups of deviant peers who encourage antisocial behavior and delinquency (Patterson *et al.*, 1992), ultimately culminating in adjustment and insertion problems. Indeed, longitudinal studies have shown that youths with behavior problems are more likely to present suicidal tendencies (Tousignant, 1993), use drugs (Hawkins *et al.*, 1992), run away from home (Kennedy, 1991), become pregnant early (Forget *et al.*, 1992), or drop out of school (Rumberger, 1995).

All in all, violence suffered and violence meted out constitute threats to the development and safety of youths, and synergetically contribute to their marginalization and social exclusion. This assessment justifies a systematic concern for both sides of the coin of violence. Young boys and girls in the care of child protection services are undoubtedly among those affected most by this twofold problem.

The Quebec Incidence Study (QIS) on cases reported to child protection services (Tourigny *et al.*, 2002) sheds unprecedented light on this clientele. Conducted in 16 of the 19 youth centers in Quebec, the QIS documented 9790 reports to child protection services, half of which were retained for evaluation. Some 39% of all the reported youths had serious behavior problems,¹ or 11 youths out of 1000 in a general population between the ages of 0 and 1 year old. Behavior problems were only second to parental neglect (43%) as a reason for reporting youths to child protection, but were the main reason for boys of all ages (children and adolescents). Moreover, one-third of all the *retained* cases involved a twofold problem, in that serious behavior problems were coupled with neglect (10%), psychological maltreatment (4%), physical abuse (3%), and other threats to development, including sexual abuse, in 3% of cases. If the past history of these youths had, in matters of reporting and maltreatment, been considered, the connection between behavior problems and victimization might have proven even more conclusive.

In summary, the literature review showed that victimization and behavior problems are two interdependent problems, both likely at the root of many future difficulties. Youths experiencing both problems simultaneously are undoubtedly among those needing the most help, requiring not only guidance and protection, but also relief from the trauma associated with violence (Harris & Fallot, 2001). From a practical point of view, one might question the extent to which our interventions are sufficiently sensitive to development trajectories and underlying dynamics of this twofold problem and, consequently, differentiated on the basis of the specific needs of these youths.

In such a context, it appears vital that efforts be directed at highlighting such trajectories, dynamics and special needs. This qualitative and exploratory study centers on youths with behavior problems who have also suffered maltreatment (psychological, physical or sexual abuse and neglect in their family environment).

Qualitative research allows a 'holistic analysis of complex, dynamic, and exceptional phenomena' (Camic *et al.*, 2003, p. 9), which corresponds precisely to the objective of this study. Ultimately, its purpose is (a) to heighten the awareness of, and provide tools for use by, caseworkers, rehabilitation specialists and teachers; (b) to help them develop a better understanding of youths in difficulty and their needs; (c) to facilitate the evaluation of reports and guidance of these youths within the social services network; and (d) to provide avenues of intervention and follow-up for these youths.

Methodology

Sample

Participants' characteristics. The qualitative sample consisted of 23 youths: 12 boys and 11 girls with ages ranging between 9 and 17, who were under the protection of the Centre jeunesse de Québec (CJQ: Québec Youth Protection), which is the institution in charge of dispatching social services to youths in need and to their families in the Quebec City area. The average age of the girls was 15, and the boys 14. About three-quarters of the youths had experienced their parents' separation and three had lost their father or mother, two of those through suicide. Only three participants were living with their biological families at the time of the study; the others were living in foster homes (n=6), group homes (n=2) and rehabilitation centers (n=12). At school, the general profile of these youths included either a lack of motivation or interest, or opposition to authority and failure to comply with rules—or both—as well as academic failure, most of these youths having repeated a school year. These data vividly illustrate the deep vulnerability of these youths in respect to their family and school environments.

Sampling strategy. The youths were selected with the help of CJQ caseworkers based on the following criteria: (1) boy or girl, age between 10 and 17; (2) behavior problems as the main reason for protection,² or contributing significantly to the intervention plan; (3) history of maltreatment. Maltreatment may or may not have been reported or covered by protective measures in the past. The most important criterion was sufficient factual information to certify the existence of maltreatment, including: (a) violence or physical abuse; (b) neglect of basic physical needs; (c) psychological violence or abuse; (d) neglect of basic emotional needs; (e) exposure to domestic violence, or (f) sexual abuse.

The sampling strategy corresponds to what Pirès (1997) calls the 'sampling through homogenization', which allows an exhaustive and in-depth study of a small group whose members share similar characteristics. Another important factor was obtaining a measure of diversity in terms of age and gender favorable to achieving empirical saturation (Mucchielli, 1996; Pirès, 1997), a key criterion in the validity of knowledge produced by qualitative research. The greater the level of empirical saturation, the more the results are transferable (i.e., valid) even when applied to other contexts. From the 35 case files referred to study leaders, 23 were selected as meeting these methodological specifications.

Data sources, instruments and procedures

Under the terms of a confidentiality agreement, two sources of information were consulted: (1) the protection files of referred youths, and (2) the CJQ's³ computerized records. Traditionally, documentation is a recognized source of information in qualitative research in the same manner as interviews and observations (Wolcott, 1992, cited in Miles & Huberman, 2003).

Protection files. The files were analyzed using a special grid based on a preliminary literature review. Kauffman's typology (Kauffman, 1997) was used to document and classify behavior problems. This typology includes hyperactivity and associated problems (impulsivity, inattention, lack of self-control), overt behavior problems (aggression, hostility, bullying, intimidation, sexual aggression), covert behavior problems (theft, lying, opposition, school problems, running away), juvenile delinquency and drug use, problems associated with anxiety and isolation (introversion, eating or sexual disorders), depression, suicidal behavior and psychotic behavior (extremely devious behavior, self-mutilation). Maltreatment was identified and classified using the Maltreatment Classification System (Barnett *et al.*, 1993), a clinical nosology developed using protection cases and providing criteria for the identification of 'emotional' maltreatment (including psychological violence and emotional neglect), physical abuse, sexual abuse, neglect in the form of lack of care and lack of supervision, and 'moral-legal-educational' maltreatment (exposing the youth to deviant models, allowing or encouraging deviant behavior).

Finally, the grid allowed the documentation of certain key factors that are considered decisive for the health and well-being of the surveyed youths, and which were likely to be found in their file. Researchers documented parental age, main source of income, family composition, history of separation, blended families and child custody, problems affecting the biological parents or step-parents (alcoholism, substance abuse, mental health issues, deficiency, domestic violence, criminality, prostitution and sex-trade work, suicide attempts, incarceration and hospitalization). In school matters,⁴ researchers documented the youths' behavior, academic records, and possible repetition of school years.

The analysis grid was then submitted to two CJQ caseworkers to test its pertinence and exhaustiveness. The grid was also pretested on two files not included in the sample database. The 23 files were then reviewed by three research assistants, referring to the grid. The assistants were instructed to examine all file contents: documents, official reports and handwritten memos by caseworkers, and then record all necessary information in the analysis grid, dating entries as precisely as possible. The assistants were instructed to enter factual information only and to exclude anything to do with the caseworkers' impressions and clinical interpretations.

To maximize the validity of the gathered data, 7 of the 23 files were reviewed by two analysts who then had to decide and agree upon the data to retain. This procedure was followed for the first four files, and thereafter, every five files in order to ensure uniformity from beginning to end of the data-gathering process.

Computerized records. The CJQ's computerized records allowed researchers to document each youth's history (dates, reasons, retention), conclusions of evaluations (founded or unfounded allegations, development or safety compromised or not), protective measures applied (dates, duration, services offered) and foster care (dates, duration, type of resource).

Qualitative analysis strategy

A case history was prepared for each youth included in the sample. In addition to organizing information in equivalent format, the procedure allowed the reconstruction of the chronology of events and life situations accompanying the development of behavior problems for each youth from his/her date of birth and at one-year intervals thereafter. Events in the parental and family history likely to have affected the youth's development were recorded as a preface to each case.

The case histories were then subjected to a sequential and synthetic analysis: 'The process allows a clustering of individual paths of development, even if it is quite obvious that on close scrutiny, each career [in this case, life history] is qualitatively distinct' (Miles & Huberman, 2003, p. 363). Using an inductive procedure, researchers were able to set a parallel between the different case histories in order to highlight differences and similarities. Matrix techniques proposed by Miles and Huberman (2003) were used to cross-reference different aspects of case histories, leading gradually to the emergence of three profiles within the sample of youths.

The researchers built a matrix for each of the three profiles and for three major developmental periods in life: pre-school age (0 to 5 years old), school age (6 to 11 years old) and adolescence (12 to 17 years old). The matrix was used to document reports and assignments to foster care, the evolution of the family structure, evidence of maltreatment and their estimated severity,⁵ the materialization of behavior problems, problems presented by the parents, school history and any other remark deemed crucial. This operation served to confirm the coherence and stability of the collections of characteristics identified earlier and to validate the typology presented here.

Results and discussion

Characteristics of youths and of their parents

The first step in the analysis documented the types of behavioral problems presented by the surveyed youths, their experience with victimization in the family environment, and the personal difficulties encountered by parents. Since the adolescents in the sample were under protective care at the youth center because of behavior problems, it was not surprising to note that they all presented significantly and clinically severe externalized behavior. Based on Kauffman's (1997) behavior problem categories, 87% of the youths in the sample presented problems of hyperactivity, impulsiveness, inattention and lack of self-control. Overt behavioral problems (aggression, hostility, bullying, intimidation, sexual aggression) were

identified among 83% of the youths, while all (100%) showed signs of covered behavior problems such as stealing, lying, opposition, problems at school and running away. Among the 23 youths of the sample, 57% had juvenile court records and used drugs. In the case of internalized problems, 70% of the youths were experiencing problems related to anxiety and isolation, and 78% were suffering from depression and showed suicidal tendencies.

Maltreatment suffered by the youths was identified and classified according to the classification system of Barnett *et al.* (1993). According to file analyses,⁶ most of the studied youths (96%) had been subjected to emotional maltreatment, including psychological violence and emotional neglect; 52% were victims of physical abuse and 17% of sexual abuse. More than three-quarters of the sampled youths were victims of neglect either in the form of lack of care (78%), lack of supervision (48%) or moral-legal-educational maltreatment, such as exposure to deviant models or encouragement to deviant conduct (70%). Several of these youths were also exposed to domestic violence (44%). Most of the youths (88%) had experienced more than one form of maltreatment, and one youth had been subjected to all documented forms of maltreatment.

Correlation analyses between the types of maltreatment and different behavior problems showed that physical abuse ($\phi=.49, p<.001$) and sexual abuse ($\phi=.54, p<.007$) were associated with inappropriate sexual behavior displayed by some of the youths in the sample. Likewise, results also indicated that lack of parental supervision was linked to youths' participation in particularly destructive behavior, such as depression ($\phi=.46, p<.02$), drug use ($\phi=.51, p<.001$), and running away ($\phi=.56, p<.02$). Table 1 presents co-occurrence percentages between maltreatment experienced in the family and the youths' behavior problems.

Descriptive data showed that these adolescents' parents were experiencing numerous personal difficulties. Mothers, in particular, had mental health problems (44%) and drug abuse problems (36%). Thirty-two percent of them had shown

Table 1. Co-occurrences between youths' behavior problems and types of maltreatment

Behavior problems	Family maltreatment					
	Domestic violence	Physical abuse	Psychological abuse	Physical neglect	Lack of supervision	Sexual abuse
Hyperactivity	39	60	80	48	56	28
Overt problems	48	64	84	56	60	28
Delinquency	52	68	88	60	64	32
Difficulties in school	52	64	84	60	64	32
Inappropriate sexual conduct	30	44**	40	36	32	28**
Drug use	26	28	44	32	48**	12
Depression	35	48	68	48	60*	24
Immaturity	52	64	80	60*	60	32
Running away from home	35	48	68	48	60*	24

Phi coefficient * $p=.05$ ** $p=.01$

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suicidal tendencies and several had been hospitalized as a result of their problems. In the case of the fathers, 35% acknowledged their involvement in criminal activities.

Phi correlation coefficients (Tables 2 and 3) between the parents' personal problems, the youths' behavior problems and their experience with the maltreatment to which they had been subjected demonstrated that the physiological abuse perpetrated by the fathers was linked closely to the youths' personal difficulties (phi coefficient varying between .56 and .60, $p < .005$). Researchers also noted significant relationships or marginally significant relationships between physical abuse and mental health problems (phi = .60, $p < .007$), suicidal tendencies (phi = .46, $p < .001$) and hospitalization of the mothers (phi = .63, $p < .007$). Likewise, behavior problems such as hyperactivity and exteriorized conduct demonstrated by youths were significantly related to personal difficulties encountered by the mothers (phi coefficient varying between .56 and 1.00, $p < .005$).

These results confirm, yet again, the relationship between serious behavior problems in youths and the maltreatment experienced within the family. Moreover,

Table 2. Co-occurrences between parents' personal problems and types of maltreatment

Parents' personal problems	Family maltreatment					
	Domestic violence	Physical abuse	Psychological abuse	Physical neglect	Lack of supervision	Sexual abuse
Alcoholism						
Mother	22	20	4	28*	20	8
Father	17	20	24**	20	16	12
Drug use						
Mother	22	24	32	32*	28	16
Father	9	12	20**	16	12	8
Mental health						
Mother	22	16	36	21	28	16
Father	13	20	24**	12	4**	12
Criminality						
Mother	9	12	16	16	16	4
Father	30*	28	36**	8	20	12
Prostitution						
Mother	4	4	8	8	4	0
Father	9	8	8*	8	0	4
Suicidal tendencies						
Mother	22	12	24	16	20	8
Father	17	20	16*	8	8	4
Incarceration						
Mother	0	4	8	8	8	4
Father	13	8	16**	12	12	4
Hospitalization						
Mother	17	8	28	0	20	12
Father	0	8	8*	0	4	0

Phi coefficient * $p = .05$ ** $p = .01$

Table 3. Co-occurrences between parents' personal problems and youths' behavior problems

Parents' Personal Problems	Behavior Problems								
	Hyperactivity	Overt problems	Delinquency	School difficulties	Inappropriate sexual conduct	Drug use	Depression	Immaturity	Running away from home
Alcoholism									
Mother	16**	28**	28	28	12	16	24	28	24
Father	20**	24	24	24	16	12	12	24	16
Drug use									
Mother	28**	36**	36	36	16	28	32	36	28
Father	16**	20	20	20	8	12	12	20	12
Mental health									
Mother	40**	44**	44	44	20	28	44*	40	36
Father	24**	24	24	24	16	8	16	16*	16
Criminality									
Mother	16**	16**	16	16	8	8	16	16	16
Father	32**	36	36	36	20	16	24	36	24
Prostitution									
Mother	4**	8**	8	8	0	8	4	8	4
Father	4**	8	8	8	4	4	0	8	0
Suicidal tendencies									
Mother	28**	32**	32	32	16	20	32	28	24
Father	16**	16	16	20	8	0	12	20	12
Incarceration									
Mother	16**	16	16	16	8	8	12	16	12
Father	16**	16	16	16	8	8	12	16	12
Hospitalization									
Mother	28**	32	32	32	8	24	32	28	24
Father	8**	8**	8	4	0	4	4	4*	8

Phi coefficient *p=.05 **p=.01

the results suggest the existence of a strong connection between the personal difficulties faced by the parents and their abusive conduct, and the manifestation of behavior problems by the youths. Although these results suggest the need for different interventions based on a background of abuse and behavior problems, they do not point to specific development of behavioral problems in youths. On the other hand, an analysis of a life history provides an efficient means of construing the chronology of events and life situations associated with the development of behavior problems in youths, thus allowing the identification of particular development profiles.

Development trajectory of behavior problems

The analysis procedure led to the emergence of three profiles among the sampled youths: they are referred to as the Undesirable, the Explosive, and the Delinquent. In the following pages, each profile is described and interpreted from a development theoretical perspective, using the attachment theory, the trauma theory and the socialization theory. Each of the profiles is also illustrated to allow readers to understand the underlying characteristics.

The Undesirable

This child is immature, dependent and demanding towards the adult. He constantly seeks the attention of his entourage, tends to be very agitated and reproduces a mechanism of social rejection by these inappropriate behaviors. These assure him that he is indeed right to be wary and surly with the people who surround him. Christian interacts in an exclusive way with others, speaks a lot and wants to control the conversation. He invents facts, wants to be informed of everything, negotiates and gives orders. He seeks the visual and body proximity of the adult. He frequently moves from one place to another without a precise goal. He has difficulty integrating in a group and insulates himself.

This profile applied particularly to five youths in the sample, three boys and two girls. It is characterized by a poor parent–child relationship since early childhood. Most of these parents are young and have several children. Results indicate a tendency to be depressive, suicidal, unavailable or uninvolved in the life of their baby or young child, leading to neglect, rejection, and even abandonment. Psychological maltreatment is consistent with this profile, from early childhood to adolescence. Usually, these youths are reported to child protection services early, sometimes as soon as they are born. If some youths experience foster care in their early childhood, all have experienced many placements during their school age. These youths show signs of immaturity and are dependent on as well as demanding of adults, exhibiting attention-seeking behavior. They tend to be very agitated, and are frequently diagnosed as having Attention Deficit and Hyperactivity Disorder (ADHD). They are inclined to create contexts for rejection, and are then ostracized by other children and adults.

From the standpoint of family dynamics, two sub-profiles emerge. The first is the scapegoat child who, given undesirable traits usually present at birth (premature birth, malformation, illness, mental deficiency, difficult temperament, extreme behavior, unwanted child, etc.), quickly becomes the target of emotional neglect, hostility and increasing explicit rejection on the part of the parents. This type of relationship is likely to exacerbate the child's problems, which then become chronic. However, the parents may show proper parenting skills with their other children. They may cooperate with caseworkers insofar as they feel hopeful that their child will 'change' (he or she being the one with the problem), but tend to withdraw when they observe that the child's behavior problems remain or intensify. They tend to deny their own attitude of rejection towards their child. This sub-profile corresponds quite closely to the 'ugly duckling' identified by Gagné and Bouchard (2004) in an earlier study, which supports its validity.

In the second sub-profile, one finds mothers with a very difficult past, including maltreatment, foster care, alcohol and substance abuse, criminal records, early pregnancies; and sometimes fathers with similar backgrounds. They usually have children very early, in a context that is not compatible with parenting. Therefore, their children end up with parents who have neither the capabilities nor the availability to take care of them properly, which leads to severe neglect and even abandonment. Usually, the parents' situation does not improve over time, which results in the child's sporadic placement in foster care and unsuccessful attempts at reintegration within the family and, by and large, more deception and disappointment.

In both sub-profiles, one is faced with adolescents whose pain is obvious, who are oppositional, non-cooperative, withdrawn and sometimes suicidal. In children with the second sub-profile in particular, illicit or delinquent behavior is also observed. Table 4 summarizes the trajectories of these youths in terms of maltreatment suffered and their predominant behavior problems. The bold print indicates characteristics specific to the Undesirable.

Links to the attachment theory. The attachment theory provides a plausible explanation for the Undesirable's behavior problems. Maltreated children, in particular those who are victims of neglect during their young childhood, often show significantly less secure attachment to their mother (or principal caregiver) than children who are not maltreated (Crittenden & Claussen, 2000; Finzi *et al.*, 2000; Wenar & Kerig, 2000; Benda & Corwyn, 2002). Moreover, children whose attachment to their mother is insecure are more at risk of developing internalized or externalized behavior problems (Cicchetti *et al.*, 1998; Finzi *et al.*, 2000; Pierrehumbert *et al.*, 2000; Benda & Corwyn, 2002).

Some characteristics typical to the Undesirable have been associated with an insecure type of attachment. The tendency to provoke rejection from others and withdraw socially has been linked to an anxious-ambivalent type of attachment (Finzi *et al.*, 2000). Benda and Corwyn (2002) observed that maltreatment experienced early in life, combined with weak attachment, can lead to suicidal tendencies or violence if the child exteriorizes his or her emotions. Finally, maternal

Table 4. Maltreatment and behavior problems of the Undesirable

Developmental period	0–5 years (n=5)	6–11 years (n=5)	12–17 years (n=4)
Maltreatment	<ul style="list-style-type: none"> • Serious psychological abuse (5/5): rejection, hostility, abandonment for indeterminate periods of time and exposure to suicide attempts • Serious neglect (3/5): malnutrition, complete lack of supervision, abandonment: parents do not take steps to meet the child's needs or solve the child's problems 	<ul style="list-style-type: none"> • Serious psychological abuse (4/5), sometimes with physical abuse (3/5): manifestation of rejection and hostility • Neglect ever present but less severe (4/5) 	<ul style="list-style-type: none"> • Psychological abuse and neglect (4/4), mostly in a context of parental disinterest and withdrawal
Behavior problems	<ul style="list-style-type: none"> • Verbal and physical aggression (4/5) • Agitation or hyperactivity (4/5) • Enuresis or encopresis (3/5) • Attention seeking (boys: 2/3), possessiveness, jealousy, need for exclusivity (girls: 2/2) 	<ul style="list-style-type: none"> • Opposition (5/5) • Verbal and physical aggression (4/5) • Agitation, hyperactivity, attention deficit or inability to concentrate (4/5) • Enuresis or encopresis (3/5) • Difficulty sharing, possessiveness, need for exclusivity (3/5) 	<ul style="list-style-type: none"> • Opposition (3/4) • Tendency to trivialize and minimize, non-cooperative (4/4) • Difficulty expressing one's emotions, withdrawn (3/4) • Suicidal ideas or attempts (3/4) • Drug use or traffic, aggressiveness, intimidation and offenses (boys: 2/3)

depression, as experienced by several Undesirables in our sample, was seen as a threat to the establishment of attachment (Cicchetti *et al.*, 1998; Crittenden & Claussen, 2000).

According to the attachment theory, the internal operating models of self and others that a child develops during his or her earliest interactions with parents underlie the onset, repetition and generalization of particular behavior patterns (Bowlby, 1988; Crittenden, 1992; Crittenden *et al.*, 2000; Zimmermann, 2000; Ramos-Marcuse & Arsenio, 2001). One might view the behavior problems of the Undesirable as strategies adapted to an adverse relationship with the parent or to a

hostile and rejecting family environment. Maladjustment will continue during development even if, with growing maturity and experience, the mental processes of managing information and associated behavior strategies evolve and become more complex (Crittenden, 2000). In fact, as the Undesirable develops, one notes a certain progression in behavior, but these more mature strategies are not necessarily better adapted. It may be inferred that the psychological maltreatment experienced by the Undesirable hinders the continuous development of more appropriate adaptation strategies. Bowlby (1988) attributed this difficulty to an anxious attachment pattern, characterized by the defensive exclusion of new experiences and information that is incompatible with pre-existing cognitive experiences.

Because the sampled youths' quality of attachment was not measured directly, and since few empirical studies have considered the issues of maltreatment, attachment and behavior problems simultaneously, researchers were limited in their ability to interpret the results obtained using the attachment theory. Moreover, the theory is controversial and presents certain limitations (Bolen, 2000).

In the case of young children whose basic needs were severely neglected, whose physical integrity and even survival were threatened, the results of studies on attachment might be reread within the perspective of developmental trauma. De Bellis (2001) mentioned having found no study exploring the post-traumatic stress of neglected children although, in his opinion, neglect might be considered a trauma, depending on the age, level of development and response of the targeted child. The perspective of trauma is explored more fully in the description of the next type of profile.

The Explosive

After traumatism, this child is much perturbed and reacts in an excessive manner facing the environmental stimuli. He loses control over his emotions and his behaviors for after a shock, his indicators have disappeared. The lack of understanding of the circle of acquaintances is accentuated by the violent reaction of the environment facing these behaviors and confirming to him that he is undesirable. He will be able to crystallize his behaviors if he receives the confirmation that he is gaining strength in his environment and this gives him a sense of control. Sebastien grew up in a family where psychological and physical and sexual violence were daily. He notably was violated over many years by his father. To complete the picture, after numerous suicide attempts, his mother threw herself in front of a train in his presence. He is violent, agitated, has precocious sexual games and already would have allegedly sexually attacked another child despite his young age (10 years).

This profile applied particularly to nine youths in the sample: six boys and three girls. The Explosive's family is marked by paternal violence and abuse. Sometimes the mother or stepmother is violent with the children, but this abuse is secondary, even an offshoot of the abuse inflicted by the father. The child may be exposed to domestic violence, be the target of physical or sexual abuse, or live in a context that combines both problems. Usually, violence is intense and repetitive, creating a

climate of fear and insecurity in early childhood and often thereafter. Occasionally, the suicide or suicide attempts of a parent add to the trauma experienced by the child. Parental criminality and deviance are frequently intrinsic to the profile, the parents themselves having important antecedents of violence that often go back to their own childhood.

Children tend to respond to this situation by exhibiting disruptive conduct and deep disorganization in terms of behavior and emotions. Over-reactions to environmental stimuli, a propensity for tantrums, a great deal of aggressiveness, violent behavior and inappropriate sexual behavior are noticed, but also depressive symptoms expressed in an 'I don't give a damn' attitude, lack of interest, and lack of goals in life. It would appear that among the Explosives there are differences in the behavior of school-age boys and girls, with girls appearing more internalized and boys being seemingly more externalized in their reactions.

While neglect plays a minor role in the Explosive's early childhood, it becomes increasingly prevalent as the child grows older. Violence gradually gives way to ingrained family disorganization, expressed mainly by lack of supervision, a deviant or chaotic lifestyle and disengagement of the parents faced with the youth's extreme behavior that they are no longer able to control. This is probably why Explosives are commonly reported and placed later than Undesirables. Even so, most are reported to child protection services before age 12, and all in this sample experienced foster care in adolescence. Table 5 summarizes the results following analysis of the files.

Links with the trauma theory. The trauma theory might help to explain the link between maltreatment and the behavior problems associated with the Explosive. Trauma is defined as 'a direct and personal experience of an event that could result in death, constitute a death threat, result in severe injury or represent a threat to a person's physical integrity', including being a witness to a situation affecting a family member or someone close. This situation causes an individual to experience 'intense fear, despair or horror (in children the response may include disorganized or agitated behavior)' (American Psychiatric Association, 1994, p. 498). Recognized childhood traumas include physical and sexual abuse, domestic violence (Boney-McCoy & Finkelhor, 1995) and exposure to a parent's attempted suicide (Eth, 2001). These are the typical experiences faced by Explosives who exhibit disorganized behavior.

It is estimated that between a quarter to a half of physically or sexually abused children will present post-traumatic stress disorder symptoms (PTSD) (Bukatko & Daehler, 2001). The numbers may be even greater among clinical populations. Children exposed to domestic violence are not spared (De Bellis, 2001). PTSD falls into three main categories: (1) re-experiencing (recurring and pervasive souvenirs or nightmares, impression of reliving the trauma, etc.); (2) avoidance (refusal to think about, or discuss, the trauma; amnesia, loss of interest, inability to arouse certain feelings, etc.); and (3) neuro-vegetative activation (irritability or excessive anger, difficulties concentrating, starting, hypervigilance, sleeping disorders) (APA, 1994). With their strong reactivity and general lack of interest in life, Explosives may well correspond to the profile of a traumatized child.

Table 5. Maltreatment and behavior problems of the Explosive

Developmental period	0–5 years (n=9)	6–11 years (n=9)	12–17 years (n=5)
Maltreatment	<ul style="list-style-type: none"> • Psychological abuse: exposure to domestic violence (6/9) • Physical abuse (6/9) • Sexual abuse (mostly girls: 3/3 and 1/6 boy) • Neglect: (4/9) minor forms compared to the violence sustained 	<ul style="list-style-type: none"> • Psychological abuse (8/9) quite severe and diversified, including exposure to domestic violence • Physical abuse (7/9): by the father or new spouse of the mother, sometimes by the mother or new spouse of the father (2/9) • Sexual abuse (4/9): continuity with childhood (2) or re-victimization in an extra-familial context (2) • Minor neglect (4/9): especially non-protection of the child 	<ul style="list-style-type: none"> • Psychological abuse (5/5): fathers little involved or more passive. Mothers more present, but more rejecting and aggressive • Physical abuse and sexual abuse cease almost completely (only one case remained) • Neglect on the increase (5/5): absence of supervision and control, permissiveness, exposure to deviant models or permission or encouragement to participate in illicit activities
Behavior problems	<ul style="list-style-type: none"> • No documented BP in most cases (6/9) • Sexual behavior and interest in sexuality (3/3) • Oppositional problems (2/3) 	<ul style="list-style-type: none"> • Sexual behavior and interest in sexuality (6/9) • Oppositional problems (6/9) • Mostly among boys: aggressiveness, conflicts and fighting (5/6), lack of self-control (3/6) or anxiety (3/6) 	<ul style="list-style-type: none"> • Disruption, emotional or extreme behavioral disorganization (4/5) • Running away from home and threatening to run away (4/5) • Theft and other offences (4/5) • Oppositional problems (3/5) • Generalized lack of interest; lack of goals (3/5)

In a survey conducted with a representative sample of young Danes aged 13 to 15, Elklit (2002) showed that even if abuse and neglect were among the traumas least frequently reported, they were the issues most strongly associated with PTSD, along with rape and suicide attempts. Interpersonal traumas, in particular sexual and

physical aggression, especially when such events occurred concurrently, were associated with symptoms more severe than non-interpersonal traumas (Green *et al.*, 2000). Based on a literature review, De Bellis (2001) maintained that experiencing severe trauma of interpersonal origin might override any factor of resilience of genetic, constitutional, social or psychological origin and increase the risk of PTSD and dysfunction associated with the majority of the victims. Related problems included opposition and hyperactivity, particularly when the trauma involved physical or sexual abuse (Ford *et al.*, 2000), and interiorized and exteriorized behavior issues (Graham-Bermann & Levendosky, 1998; Livingston-Smith *et al.*, 2000), problems frequently observed among Explosives.

To explain the connections, developmental trauma experts (Fishbein, 2000; De Bellis, 2001) maintained that, consistent with yet-to-be-understood mechanisms, maltreatment directly affected some loosely interconnected neurobiological systems. Disruption of these systems then translated into physical and cognitive development problems and emotional and behavioral difficulties that increased the risk of inappropriate conduct. From a more ecological standpoint, Harvey (1996) added that the intensity of the behavioral response of a traumatized individual is based on a complex interaction between individual factors and environmental contingencies. Such hypotheses highlight the urgent need for a substantial investment in the prevention of maltreatment, and early intervention. Indeed, these hypotheses imply that the treatment of traumatized adolescents may require a combination of pharmacological, psychotherapeutic, social and educational interventions, which poses an enormous and costly social challenge.

The Delinquent

This child grew up in a violent family environment, harsh, incoherent and emotionally poor. He has interiorized that he can do whatever he wants without having consequences because the parental engagement is deficient. Violence is used to obtain control and dominate others. He distinguishes himself from the two other profiles because of the adoption of behaviors at risk, such as the use of alcohol and drugs, of sexually precocious behaviors and the association to peers deviating. Caroline is agitated, violent towards other children and does not respect the goods of others. She has very precocious sexual behaviors for her age and is identified by others as being open to this kind of activity. She has run away many times. She confronts all authority.

This profile applied particularly to nine youths in the sample: three boys and six girls. This was the most difficult profile to document, because the youths were referred at the onset of adolescence. Consequently, their files contained a limited amount of sporadic information on their developmental background. Specifically, their parents were older than the parents of the children in the other two profiles, and their families smaller. Several were the only child in the family; among the others, siblings were often half-brothers and half-sisters, or children of the new spouse, with large age differences. Indeed, only the minority of Delinquents still live

with their two parents at the end of their early childhood; in most cases, their father is hardly or no longer present in their lives. Their mother is ordinarily burdened with a painful and difficult past. Overwhelmed by her own difficulties, she is not what might be termed a mistreating mother; rather, she is overtaken by events, powerless; or, then again, enmeshed and indifferent. She may occasionally resort to psychological violence, but is above all characterized by her lack of consistence and firmness in the application of a lifestyle. Even when a father figure is present, chronically ineffective child supervision remains the main constant of this profile. These youths seem to have learned that they can do anything they like without having to suffer the consequences. They resist any form of supervision or discipline and develop severe oppositional problems and antisocial behavior.

Although their behavior does not differ greatly from that of the Explosives, it is nonetheless less disorganized and more structured around a marginal lifestyle. Their aggressive behavior aims at gaining power. These youths tend to take major risks that could compromise their development and safety. They are frequently substance abusers who ordinarily began taking drugs before adolescence. Girls seem particularly vulnerable to extra-familial sexual abuse and prostitution. Protective intervention usually strives to put a stop to their destructive behavior, and all these youths end up in institutional placement during adolescence. Table 6 summarizes the results obtained.

Insofar as these youths have not been the victims of maltreatment *per se*, one may question the reason underlying their referral to this study by caseworkers. In this respect, one should remember that most are girls. From a social point of view, it may be easier to identify girls as victims. Moreover, among the three boys, two also presented some of the characteristics present in the Undesirables, more particularly with regard to behavior problems. It might be easier to identify a Delinquent boy as a victim if he allows some suffering or some depressive behavior to show through, which may be less necessary among girls. As a result, there could be a certain amount of bias in the sampling specific to the profile of Delinquents.

Links with the socialization theory. The socialization theory, whereby an individual learns through role modeling and extrinsic reinforcement (Bandura, 1973; Huesmann, 1988; Berkowitz, 1993; Coie & Dodge, 1998), appears a relevant way of explaining the Delinquent's behavior problems. In this model, the quality of the affective relationship between the parent and child, and more particularly the parents' educational and disciplinary practices, constitute determining factors that could lead to the emergence of behavior problems in a child. The work of Patterson and his colleagues (1992; Chamberlain & Patterson, 1995) clearly shows that families of youths who developed, maintained and generalized antisocial behavior are characterized by extremely tolerant attitudes or permissiveness with respect to unacceptable behavior from the youth or, on the contrary, are excessively controlling or coercive. In this study, the Delinquents' families exemplified chronic inefficiency or inconsistent supervision.

In such a family environment, the child develops and uses opposing and coercive conduct, and learns to exercise control over others. The absence of consequences

Table 6. Maltreatment and behavior problems of the Delinquent

Developmental period	0–5 years (n=9)	6–11 years (n=9)	12–17 years (n=5)
Maltreatment	<ul style="list-style-type: none"> No documented maltreatment in most cases (6/9) Psychological abuse (2/3 severity difficult to estimate) Sexual abuse (1 girl) by the son of the mother's spouse 	<ul style="list-style-type: none"> No documented maltreatment (3/9) Psychological abuse (4/6 severity difficult to estimate) Occasional physical abuse and neglect (1/4) Abandonment by the mother (1 boy) 	<ul style="list-style-type: none"> Occasional psychological abuse+neglect (9/9): generally by the mother (verbal violence, rejection, favoritism, threats of suicide or attempted suicide, abandonment) Poor parental skills (9/9); lack of parental supervision and neglect (5/9)
Behavior problems	<ul style="list-style-type: none"> No documented behavior problems 	<ul style="list-style-type: none"> No documented BP in ¼ of the situations Onset of drug use (5/7) School adaptation problems or academic difficulties (4/7) 	<ul style="list-style-type: none"> Drug use (9/9) Running away from home and threatening to run away (9/9) Opposition, rebellion, refusal to accept authority, confrontation (8/9) Aggressiveness and verbal or physical violence (8/9) Talk about, suicidal ideas or threats of committing suicide (7/9): 3 youths attempted to commit suicide Associating with older, delinquent or at risk peers (6/9) Theft, fraud, extortion (6/8) Prostitution (3/6 girls suspected of engaging in prostitution)

and the gains obtained by aggressive children (parent backing off, avoiding tasks, etc.) lead them to overestimate the advantages to be obtained from this kind of behavior. It encourages them to resort to this method of acting at home and at daycare, then at school with peers and adults (Brown *et al.*, 1996; Dodge *et al.*, 1997). The child's aggressiveness manifests itself through domineering and controlling designs (proactive aggression), or then again through an excessively

aggressive reaction to contradiction (reactive aggression), two reactions typical of our Delinquents. Their behavior problems are maintained and even aggravated over time. This deterioration is attributable to violent models and to the reinforcement of these types of behavior in parent-child interaction (Dodge *et al.*, 1990; Eron, 2000). In such families, the erosion of parental abilities may be linked to difficult life circumstances, such as unemployment, separation, marital conflict, alcoholism or depression (Farrington & Loeber, 1998; Hill, 2002).

In summary, the families of Delinquents present many of the characteristics associated with the dysfunctional families described above. It is clear that the youths in this profile are not given adequate supervision within their family. Controlling or violent parental models appear less present; however, the absence of a father figure in early childhood should be noted. Indeed, Delinquents commonly go through their parents' separation when very young; in many cases, contact with their father is not maintained. Custody is generally awarded to the mother, who is often fragile and faces serious personal difficulties (depression, suicidal ideas, mental health problems), which might explain difficulties in properly supervising her children. Faced with the failure reflected in the increasing uncontrollable behavior of her child, the mother may adopt psychologically inappropriate relational attitudes. This kind of relational dynamic is similar to the 'powerless parent and terrible child' identified by Malo *et al.* (2003) in an earlier study. Such considerations highlight the urgency of tracing these vulnerable families and providing parental support at an early stage and, more particularly, of implementing a firm disciplinary framework that is both coherent and non-coercive in early childhood.

Recommendations for intervention in the school environment

The results of this study suggest that youths exhibiting inappropriate and violent behavior may have distinct histories and functional dynamics that could be explained by different conceptual frameworks. This assessment in turn points to the specific needs of these youths, particularly in a school environment.

With a history of neglect and rejection, the Undesirable is relationally fragile. It is important to avoid rejecting such youths once again, and to protect them from peer rejection, intimidation and bullying, because they may become an ideal scapegoat. Some studies suggest that the establishment of significant attachment to a teacher is not only possible (Howes & Ritchie, 1999; Ramos-Marcuse & Arsenio, 2001), but also beneficial to these children. It might help improve their ability to learn, encourage the emergence of appropriate behavior, and neutralize the impact of difficulties experienced at home (Atwool, 1999).

The establishment of such a relationship with a significant adult might prove central to supporting the resilience of severely neglected or abandoned youths, and may constitute a turning point in their lives (Drapeau *et al.*, in press). Simply paying attention to the youths' attitude and positive conduct, and showing them approval, offers a reflection of their worth. On the other hand, compliments, encouragement and warm physical contact may raise suspicion, provocation and even aggressiveness

in the Undesirable. It might be preferable to proceed indirectly by inviting the youth to engage in an exercise of self-assessment, and then offer help in reassessing the evaluation if necessary. According to the attachment theory, to change an individual's warped perception of themselves, of others, and of interpersonal relations is a long-term proposition. Eventually, a better-adapted coping style and greater self-esteem may serve as the foundation for the development of pro-social skills and positive social insertion.

In the case of the Explosive, efforts should be made to avoid situations that might place the youth in contact with the trauma of violence, including coercive interventions and anything that could take them by surprise (spontaneous physical contact, unforeseen consequences, etc.). These circumstances can lead to strong reactions, even complete disorganization. One should respect the Explosive's efforts at evasion and even help them think of something else by, for example, persuading the youth to become involved in activities in which they may play a useful or constructive role, where people will trust and help them to feel competent and useful. Bolstering the resilience of abused youths might well take root in such activities (Drapeau *et al.*, in press). Supervision must be firm, but warm, allowing anticipation of events. Exposure to suitable adults provides the Explosive with role models for identification and teaches the youth that violence is not necessary in order to master the intricacies of life. Thanks to such support, the youth may gradually deal with their traumatizing experience and with the painful feelings associated with it, integrate the experience into their life and give it meaning, thereby hastening the healing process (Harvey, 1996; Kennedy & McCarthy, 1998).

However, both the Undesirable and the Explosive may resort to verbal or physical violence with peers and authority figures. Avoiding coercive interventions does not signify acceptance of such behavior. Ideally, the consequences should be foreseeable, proportional to the committed act, as well as logical (i.e., require that the youth repair the damage, or that they withdraw from an activity temporarily, etc.), and applied calmly and sensibly. One should also plan and implement a procedure so that tantrums and major disorganization may be managed within the school setting. Expelling the child and returning them to the family environment is to be avoided, first because the parents of these youths are usually negligent, dismissive and violent; and second, because expulsion once again confirms to the youth that they are undesirable. Eventually, such youths might be targeted for participation in a pro-social skills development program. In this way, the problem is tackled positively and proactively, instead of negatively and reactively, in itself a good example to offer the youth.

Given their propensity for breaking rules, Delinquents may resort to manipulation or cunning to avoid facing the consequences of their actions, even if expectations have been clarified earlier. It is important to avoid negotiating with the Delinquent, but instead to remind them that they were aware of the rule and then applying the foreseen sanction. Goaded by frustration, the Delinquent may react with hostility, intimidation, threats and even aggression. Such actions are not to be tolerated under any circumstance. More serious actions (threats, assault) should be reported

systematically, and a complaint should be lodged with services empowered to arrest the youth. This kind of intervention must be made to protect other students, school staff, and the young aggressor themselves. Indeed, in the case of the Delinquent, putting an end to such action is vital. By heightening their awareness of the dead-end situation in which they now find themselves, this type of intervention could prove to be a turning point for change in a youth spurred by anger, revolt or fear of more far-reaching consequences (Drapeau *et al.*, in press). In addition, preventing the youth from further action will allow them to obtain the help that they would undoubtedly refuse if it had not been imposed. One must intervene with such youths from an *empowerment* (they alone can choose to change) perspective, and seek to decrease misdeeds inflicted on themselves and others. Because such youths are frequently affiliated with antisocial peers with marginal lifestyles, they must be led to identify palliatives to their former lifestyle (including drug consumption), invest in them, forge other kinds of social ties, and develop the ability to be self-assertive with former friends.

Conclusion

This qualitative research highlighted three development profiles leading to serious behavior problems among youths with a more or less serious past history of maltreatment. By integrating the results with recognized child and youth development theories, it is possible to propose concrete intervention strategies. This study provides an example of 'research-theory-practice' integration that we believe to be worthy of attention.

Typologies are essentially reductionist in nature and help us better understand complex phenomena. In truth, it is possible that a youth may present both the characteristics of the Undesirable and the Explosive, or then again the characteristics of the Undesirable and Delinquent, without invalidating the typology proposed. On the other hand, identifying a youth with both a history of maltreatment and behavior problems not falling within any of the three profiles identified in this article would challenge the typology proposed. This is why, ideally, this type of result should be subjected to a continuous validation process.

The typology brings forth results from a co-construction that involved case-workers, who entered information in the child protection files, research assistants, who extracted the required information, and researchers, who analyzed the information. It is always possible to assume that other files might have led to the identification of other profiles, or that other researchers might have noted different observations from the corpus of information. However, great care was taken with sample selection and the achievement of empirical saturation. The consensus procedure applied to file review also supports the value of the proposed typology. Moreover, the typology is backed by the results of another qualitative study conducted concurrently, consisting of interviews with adolescent boys and girls in the care of child services (Drapeau *et al.*, in press). Based on the 'turning point' type, which centers on the resilience process or the relation, action and reflection, this

study identifies three groups of resilient youths. The three groups might well represent the Undesirable, the Explosive and the Delinquent, respectively. One might consider the results to be mutually validating, although other studies will be necessary to verify this hypothesis.

Given the small size of the sample, this type of research does not permit result-based generalization. However, the results may be transferable to anyone wishing to use them, insofar as they are situated within one's own research or intervention context. Without claiming to have developed a new theoretical model to explain serious behavior problems among maltreated youths, this study provides a contribution to our understanding of the phenomenon, and generates useful and sensible research hypotheses for future research.

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Notes

1. Most serious behavior problems are linked to relationship problems with parents or authority, conduct at school, alcohol or substance abuse, verbal or physical violence inflicted on others, self-destructive behavior and risk taking. At school, they also include deliberate absenteeism, suspensions and expulsion.
2. In Quebec, the Youth Protection Act also covers behavior problems deeming them a situation deleterious to the safety and development of a child when parents fail, or are unable, to take the means to put an end to the situation.
3. Under the terms of the law, information on a youth is kept for a maximum of five years after his/her file is closed. Concretely, this means that when a file is closed after protective measures have been terminated and the youth in question is not reported to child services over the next five years, information concerning this youth may be destroyed. This is a limitation inherent in the privileged source of information used in this study.
4. Information on the youth's school history is fragmentary at best, given its source. The information is an offshoot of what youth caseworkers deemed to be of interest for inclusion in the protection file. Therefore, the information varies from one file to the next.
5. The Maltreatment Classification System (Barnett *et al.*, 1993) provides a five-point scale to estimate the severity of each form of maltreatment. Analysts referred to this scale to estimate the relative severity of each case. However, no inter-judgment agreement index was calculated

for the severity estimates. This is why results on the severity of maltreatment are reported globally, as indications only and when deemed pertinent to characterize a particular profile.

6. Percentages appearing between parentheses indicate the proportion of youths in the sample for whom the dimension in question was identified, with all levels of severity taken together. In the case of physical and sexual abuse, the proportions represent only those cases deemed founded and excluded any cases in which the caseworker might have evinced doubt.

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Victim Age-Based Subtypes of Juveniles Adjudicated for Sexual Offenses: Comparisons Across Domains in an Outpatient Sample

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Abstract

Adolescents adjudicated for sexual offenses are a heterogeneous group. The identification of more homogeneous subgroups of offenders may enable improved treatment, as the specific risks and needs presented by each group could be more effectively targeted. The current study examines three subgroups derived based on the age of victim(s), a popular method of subtyping that has mixed empirical support, using a sample of 176 males adjudicated for a sexual offense and court-ordered to participate in a community-based collaborative intervention program that integrates treatment and probationary services. Differences expected between groups based on theories regarding victim-age based subtypes are examined, in addition to differences consistently identified in prior research. Results indicate that these three subgroups are more similar than different, although some expected differences were found. Juveniles with child victims were more likely to have male victims and biologically related victims. Juveniles with peer/adult victims were more likely to have poor monitoring by their parents and more likely to have been arrested again. Juveniles with mixed types of victims appeared similar to juveniles with child victims on some variables and similar to those with peer/adult victims on others. Treatment implications and future directions for research are discussed. Typologies based on clinical characteristics of the youth rather than offense characteristics may have more promise for identifying meaningful subgroups.

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The serious problem presented by juveniles who engage in sexually abusive behavior is now well recognized. Juvenile offenders represented more than 16% of arrests for sexual crimes in 2009 (U.S. Department of Justice, Federal Bureau of Investigation, 2010) and are responsible for more than a third of sexual crimes against children (Finkelhor, Ormrod, & Chaffin, 2009). Juveniles adjudicated for sexual offenses (JSOs) are now viewed as uniquely dangerous and are subject to specialized legal and clinical interventions (Chaffin, 2008; Letourneau & Miner, 2005; Zimring, 2004). These public policy and clinical approaches, such as the inclusion of JSOs on public registries and the application of relapse-prevention treatment strategies, have outpaced empirically based knowledge about this population of offenders. JSOs are known to be a heterogeneous population (e.g., Fehrenbach, Smith, Monastersky, & Deisher, 1986; Graves, Openshaw, Ascione, & Ericksen, 1996; Herkov, Gynther, Thomas, & Myers, 1996; Jacobs, Kennedy, & Meyer, 1997), therefore a greater understanding of this population would be provided by the development of an empirically based typology (e.g., Becker & Hunter, 1997; Veneziano & Veneziano, 2002). Such a typology would provide important information for clinical interventions by identifying key constructs for assessment, possible etiological factors specific to each subtype of offender, and unique risks and needs for each subtype that should be targeted in treatment. Treatment efforts could therefore be more effective and more efficient through targeting treatment by subtype. Furthermore, recent research suggests that the identification of relevant subtypes may improve risk assessment practices (Rajlic & Gretton, 2010), potentially allowing social control interventions like inclusion on public registries to be limited to the highest risk youth. Several methods of subtyping offenders have been suggested, and the validity of such subtyping schemes can be evaluated by determining whether subgroups differ on theoretically relevant variables.

Subtypes of Adult Offenders Based on Victim Age

One frequently studied method of subtyping adult sex offenders uses the age of their victim(s) to establish subgroups. Several models of the etiology of sexual offending against children highlight the role of sexual victimization (e.g., Hall & Hirschman, 1992; Seto, 2008; Ward & Siegert, 2002), with such victimization being hypothesized to lead to offending against children through the adoption of deviant sexual scripts (Ward & Siegert, 2002), modeling, conditioning, or other disruptions to normal sexual development (Seto, 2008). Other commonly identified etiological factors related to offending against children include social skills deficits (e.g., Hall & Hirschman, 1992; Marshall & Barbaree, 1990; Ward & Siegert, 2002), cognitive distortions (Hall & Hirschman, 1992; Ward & Siegert, 2002), and problems in self-regulation (Hall & Hirschman, 1992; Ward & Siegert, 2002). Some of the same factors have been hypothesized to be related to the development of all sex offending regardless of victim age

(e.g., sexual victimization, Marshall & Marshall, 2000; self-regulation problems, Stinson, Sales, & Becker, 2008). Others suggest that adults who commit sexual offenses against postpubescent victims have negative views of women, substance abuse problems, condone violence, are hypermasculine (Robertiello & Terry, 2007) and are similar to violent nonsexual offenders (Harris, Mazerolle, & Knight, 2009).

Research on adult sex offenders has supported the existence of some expected differences between groups, as adults who select child victims are more likely to have been sexually abused (e.g., Jespersen, Lalumière, & Seto, 2009), have greater perceived deficits in social skills, and greater social anxiety (e.g., Segal & Marshall, 1985), whereas adults who offend against postpubescent victims are more generally antisocial (e.g., Olver & Wong, 2006; Porter, Fairweather, Drugge, Hervé, Birt, & Boer, 2000; Quinsey, Rice, & Harris, 1995) and have higher violent (nonsexual) recidivism rates (e.g., Prentky, Lee, Knight, & Cerce, 1997; Quinsey et al., 1995). Comparisons between subtypes of adult sex offenders based on victim age have thus consistently demonstrated meaningful differences between groups that are expected based on existing theory. These differences suggest potentially unique etiologies as well as treatment approaches for the subgroups. The success of this method of subtyping adult offenders has led to research examining the validity of this distinction among juveniles adjudicated for sexual offenses.

Subtypes of Juveniles Adjudicated for Sexual Offenses Based on Victim Age

Although this method of subtyping has intuitive appeal, the meaning of the selection of a child victim when the perpetrator is himself (or herself) still a minor is not entirely clear. It appears that theories regarding these subtypes of adult offenders have simply been extended downward to juveniles. Robertiello and Terry (2007) described the typically expected differences between these groups:

Those who abuse children . . . rely on opportunity, trickery, bribes, and threats, and often experience deficits in self-esteem and social competence. They lack social skills and show signs of depression. Juveniles who victimize peers and adults often commit sexual offenses in conjunction with other criminal behavior and exhibit a more generalized type of delinquency. These offenders are more likely to target strangers, use weapons, and cause injuries to their victims. (p. 515)

In addition, Seto and Lalumière (2010) hypothesized that “sexual victim age might . . . be an important moderator for some special explanations of adolescent sexual offending” (p. 532); therefore, theories regarding the etiology of sexually abusive behavior in juveniles might be specific to the etiology of offenses against children. Seto and Lalumière (2010) identified factors commonly theorized to contribute to the development of sexual offending in adolescents, which therefore may be associated specifically with the development of abuse of children: sexual victimization, poor childhood attachment, social incompetence, disruptions in sexual development, atypical

sexual interests, psychopathology, and cognitive limitations. Support for these theories would thus be provided by demonstrating greater problems in these areas among juveniles who have victimized children.

Research regarding these expected differences has been largely inconsistent, however, in both methods and results. Studies differ in their operational definition of child victims (e.g., below age 12 and at least 3 years younger than offender: Carpenter, Peed, & Eastman, 1995; 4 or more years younger than offender: Richardson, Kelly, Bhate, & Graham, 1997); however, these definitional differences neither significantly alter the composition of subgroups nor the differences found between groups (Kemper & Kistner, 2010). In addition, existing studies differ in the assessment measures used (e.g., different measures of mental health functioning in Carpenter et al., 1995; Hunter, Figueredo, Malamuth, & Becker, 2003; Ronis & Borduin, 2007) and whether structured assessments are used at all (e.g., 't Hart-Kerkhoffs, Doreleijers, Jansen, van Wijk, & Bullens, 2009). Perhaps such methodological inconsistencies between studies have contributed to the inconsistent results produced to date.

Brief descriptive information and major findings of studies on victim-age-based subgroups are presented in Tables 1 and 2. As noted above, subtyping schemes can be validated by demonstrating theoretically expected differences between groups. The variables used to examine theoretically expected differences may be considered "psychologically meaningful" (Mann, Hanson, & Thornton, 2010, p. 194). The victim-age-based method of subtyping has not yet been accepted as a valid typology for JSOs because the few consistent differences identified to date are not related to etiology, treatment outcome, or recidivism. The review below highlights results related to theoretically expected differences (i.e., psychologically meaningful variables) which have produced largely inconsistent findings to date, results that have been consistent across studies, and results regarding risk and recidivism. The potential role of disruptions in sexual development, atypical sexual interests, and cognitive limitations will not be included in the review below as they could not be addressed in the current study.

Research Regarding Psychologically Meaningful Variables

Juveniles who offend against children are expected to have higher rates of sexual victimization than those who offend against peers or adults. A number of studies demonstrate such a finding, although they differ regarding whether the effect was noted for all juveniles with child victims (Ford & Linney, 1995; 't Hart-Kerkhoffs et al., 2009; Hummel, Thömke, Oldenbürger, & Specht, 2000), only those with male child victims (Worling, 1995), or those that have offended against both child and peer/adult victims (Richardson et al., 1997), and some studies did not find a significant difference ('t Hart-Kerkhoffs et al., 2009; Hendriks & Bijleveld, 2004; Ronis & Borduin, 2007). A recent meta-analysis did find that juveniles with child victims were significantly more likely to have a history of sexual (but not physical) abuse than juveniles with peer/adult victims (Seto & Lalumière, 2010). Further evidence of differences between

Table 1. Previous Findings Regarding Differences Between Subgroups in Individual and Family Characteristics

Study	N	Sample characteristics	Individual characteristics	Family characteristics
Carpenter, Peed, and Eastman (1995)	36	17- to 19-year-olds ordered to receive sex offender treatment in a residential youth correctional facility. No MV group.	No differences in age, race/ethnicity, prior sex offenses, prior nonsex offenses, prior enrollment in treatment, or MCMI Histrionic, Narcissistic, or Antisocial scales. CV scored higher on the MCMI Schizoid, Avoidant, and Dependent scales.	NA
Ford and Linney (1995)	35	9- to 18-year-olds ordered into state-operated facilities. No MV group.	No differences in age, educational status, self-concept, and social skills. CV less likely to have prior offenses and reported greater exposure to pornographic magazines at young ages.	No differences in family structure, family size, or family criminal history. CV reported more intrafamily violence. A greater proportion of CV reported being sexually victimized.
Gunby and Woodhams (2010)	43	10- to 17-year-olds referred to East Midlands Youth Offending Teams. No MV group.	No differences in mental health problems. CV were more frequently the victims of bullying, had fewer age-appropriate friends, and had more negative self-esteem. PV more frequently came from deprived homes.	No differences in familial substance use. PV experienced more inconsistent supervision, had greater familial criminal involvement, and were more likely to have witnessed family violence. CV more frequently lived in "chaotic" households.
Hagan and Cho (1996)	100	12- to 19-year-olds who successfully completed mandatory treatment program in a correctional facility. No MV group.	NA	NA

(continued)

Table 1. (continued)

Study	N	Sample characteristics	Individual characteristics	Family characteristics
Hagan, Gust-Brey, Cho, and Dow (2001)	100	Same sample as above	NA	NA
't Hart-Kerkhoffs, Doreleijers, Jansen, van Wijk, and Bullens (2009)	174	12- to 18-year-olds suspected of having committed a sex crime. No MV group.	No differences in externalizing problems, environmental conditions, substance abuse, school problems, or leisure-time functioning. CV demonstrated more problems in psychosocial development and internalizing problems.	CV more frequently reported problematic familial circumstances.
Hendriks and Bijleveld (2004)	116	11- to 18-year-olds prosecuted for a sexual offense for whom psychological testing had been requested. No MV group.	No differences in extraversion, sensation seeking, sexual abuse, or prior nonsex offenses. CV scored higher on neuroticism, were more likely to have psychopathology, were more often the victims of bullying, had lower self-image, had poorer peer relationships, were more likely to be of Dutch origin, were younger at the time of the offense, and were more likely to have a previous sex offense.	No differences in cruelty by parents, neglect by parents, or interparental violence.
Hummel, Thömke, Oldenbürger, and Specht (2000)	74	14- to 20-year-old defendants accused of sexual offenses. No MV group.	CV were more often victims of sexual abuse (significance testing not reported)	NA

(continued)

Table 1. (continued)

Study	N	Sample characteristics	Individual characteristics	Family characteristics
Hunter, Hazelwood, and Slesinger (2000)	126	Records provided by police officers in training at FBI Academy. Age range not provided. No MV group.	No differences in age at time of offense, prior general arrests, prior sexual offense arrests. CV were predominantly White, PV were predominantly African American.	NA
Hunter, Figueredo, Malamuth, and Becker (2003)	182	12- to 18-year-olds treated in residential facilities (correctional and noncorrectional). No MV group.	No difference in prior arrests for sexual crimes. CV had greater deficits in psychosocial skills, were more likely to score in clinically significant range for depression and anxiety on the Youth Self-Report, and had a prior arrest for a nonsexual assault more frequently.	NA
Kaufman, Hilliker, et al. (1996) ^a	179	13- to 20-year-olds from two juvenile correctional facilities. Analyses used age of youngest victim.	A history of abuse was associated with selecting younger victims.	NA
Kemper and Kistner (2007)	296	12- to 19-year-olds in a juvenile residential training school (correctional facility).	No differences in FSIQ, age at admission, age at first sex offense, number of commitments to DJJ facilities, or age at first arrest. CV were more likely to be White, those who offended against peers were more likely to be African American. PV had more nonsexual charges.	NA

(continued)

Table 1. (continued)

Study	N	Sample characteristics	Individual characteristics	Family characteristics
Kempton and Forehand (1992)	15	11- to 18-year-olds in a correctional facility. No MV group.	No differences between groups on the Anxiety, Inattentive, Aggressive, or Social/Withdrawal subscales of the Teacher Report Form.	NA
Långström and Grann (2000)	46	15- to 20-year-olds referred for an evaluation of insanity. No MV group.	NA	NA
Parks and Bard (2006)	156	12- to 17-year-olds in a juvenile correctional facility.	No differences between groups on age at index offense, age at admission or discharge from the institution, FSIQ, VIQ, or PIQ. PV were more often African American, with more Whites in the CV and MV groups.	NA
Rasmussen (1999) ^b	170	7- to 18-year-olds adjudicated for a sexual offense.	NA	NA
Richardson, Kelly, Bhate, and Graham (1997)	100	11- to 18-year-olds referred for psychological and/or psychiatric assessment. Half of MV group victimized a younger sibling and an unrelated child.	No differences in diagnosis of psychosis, depression, or conduct disorder. MV had earlier age of onset than CV and PV. A greater proportion of MV had been sexually abused than CV and PV. PV were more likely to have engaged in theft and assault and to have antisocial peers than other groups. MV and PV were more likely than CV to have school behavior problems.	No differences between groups in rates of experiencing or witnessing family violence. MV and CV were more often considered at risk of neglect or abuse by social services and were more often categorized as a "problem family" by social services.

(continued)

Table 1. (continued)

Study	N	Sample characteristics	Individual characteristics	Family characteristics
Ronis and Borduin (2007)	46	10- to 17-year-olds referred to the Missouri Delinquency Project. No MV group.	No differences in age, number of arrests, SES, race, sexual or physical abuse, scores on the Revised Behavior Problem Checklist (anxiety, attention, conduct disorder, and aggression), scores on the Global Severity Index of the Brief Symptom Inventory, scores on the Missouri Peer Relations Inventory (emotional bonding and aggression) or academic performance.	No differences in proportion living with two parents, scores on the Family Adaptability and Cohesion Evaluation Scales-II, or ratings of negative affect, or facilitative exchange in an observational task.
Smith and Monastersky (1986)	112	10- to 16-year-olds referred to a community evaluation and treatment program. No MV group.	NA	NA
van Wijk et al. (2007)	578	12- to 20-year-olds who were evaluated by the forensic mental health service in the Netherlands. No MV group.	No differences in age. Developmental disorder and cluster C personality disorders were more common among CV. PV were similar to violent nonsex offenders.	NA
van Wijk, van Horn, et al. (2005)	112	Same as above.	No differences in age, self-esteem, or being a victim of bullying. CV were more often White, whereas PV were more often ethnic minority.	NA

(continued)

Table 1. (continued)

Study	N	Sample characteristics	Individual characteristics	Family characteristics
Worling (1995)	90	12- to 19-year-olds in outpatient treatment. No MV group.	<p>Post hoc tests not reported but differences reported between groups on neuroticism (CV higher), IQ (CV higher), school-dropout rate (CV lower), and bad contact with peers (PV higher).</p> <p>No differences in age or SES. No differences between juveniles with female child and female peer/adult victims in sexual abuse rates, which were significantly lower than the rates of sexual abuse among juveniles with any male child victim.</p>	NA

Note: CV = Juveniles with child victims; PV = Juveniles with peer/adult victims; MV = Juveniles with mixed victim types. Some samples included nonsexual offenders; in these instances, only the number of sexual offenders are included in the N. A meta-analysis by Graves, Openshaw, Ascione, and Erickson (1996) is excluded because the "sexual assault offender" group is described as including victims of varying age, including victims younger than the offender.

a. (K. L. Kaufman, et al., 1996) did not create two categories (child vs. peer/adult). Victims divided into the following age ranges: 0-3, 4-6, 7-9, 10-12, 13-17.

b. Rasmussen (1999) did not compare based on victim age categories but used age of victim as a predictor of recidivism.

victim-age based subgroups is needed, given the mixed results to date, to support theories that propose a major etiological role for child sexual victimization in the development of offending against children.

Juveniles who offend against children are expected to have higher rates of mental health problems as well. Currently, evidence regarding differences in problems with anxiety is mixed (Hunter et al., 2003; Kempton & Forehand, 1992; Ronis & Borduin, 2007), although there is some consistent evidence that those with child victims are more likely to have internalizing problems (‘t Hart-Kerkhoffs et al., 2009; Hendriks &

Table 2. Previous Findings Regarding Differences Between Subgroups in Offense Characteristics, Victim Characteristics, and Risk to Reoffend

Study	Offense characteristics	Victim characteristics	Risk to reoffend and recidivism rates
Gunby and Woodhams (2010)	PV were more likely to use violence to control victims.	CV more often selected victims known to the offender.	NA
Hagan and Cho (1996)	NA	NA	No differences in sexual or general recidivism rates over 2-year follow-up. No differences in the severity of subsequent offenses.
Hagan, Gust-Brey, Cho, and Dow (2001)	NA	NA	No differences in sexual recidivism over 8-year follow-up.
't Hart-Kerkhoffs, Doreleijers, Jansen, van Wijk, and Bullens (2009)	CV less likely to use excessive violence. A greater proportion of CV reported feeling sexual excitement during offense.	CV more likely to offend against a male and less likely to offend against a stranger than PV.	No differences in sexual recidivism. PV who committed offense in a group had higher general and violent recidivism rate than PV who committed offense alone and CV.
Hendriks and Bijleveld (2004)	CV more likely to use verbal violence or threats and less likely to use physical violence than PV.	CV less likely to offend against a stranger and more likely to have a male victim than PV.	NA
Hunter, Hazelwood, and Slesinger (2000)	No differences in rates of transporting the victim, murdering the victim, or use of a weapon. PV more likely to commit the offense with co-offenders, more likely to commit the offense in the context of another crime, and more likely to use force than CV.	No difference in the rates of having multiple victims. PV had more female victims and more stranger victims than CV. Child victims more likely to use no or passive resistance strategies, peer/adult victims more likely to use verbal or physical resistance strategies.	NA

(continued)

Table 2. (continued)

Study	Offense characteristics	Victim characteristics	Risk to reoffend and recidivism rates
Hunter, Figueredo, Malamuth, and Becker (2003)	No differences in rates of actual or attempted intercourse or presence of co-offenders. PV used greater force, used a weapon more often, and were under the influence of alcohol or drugs at the time of the offense more often. CV more likely to commit the offense at victim's home.	No difference in likelihood of having multiple victims. CV more likely to have offended against a relative.	NA
K. L. Kaufman, et al. (1996) ^a	Juveniles who offended against younger victims were more likely to give gifts and/or use love and attention to gain victim's trust, less likely to use alcohol or drugs, more likely to threaten the relationship and to use withdrawal of benefits.	NA	NA
Kemper and Kistner (2007)	MV had more adjudications and victims (even when compared with CV and PV with more than 1 victim). CV less likely to engage in penile penetration. CV and MV more likely to have engaged in oral sex. MV engaged in a greater variety of sexual acts than CV, who in turn engaged in a greater variety than PV.	CV and MV more likely than PV to have victims of both genders, less likely to have only female victims, and more likely to victimize only family members.	No differences in nonsexual or sexual recidivism rates over an average follow-up of 5.22 years. MV more likely than both other groups to be treatment noncompleters, although there were no differences in rates of removal from group treatment.

(continued)

Table 2. (continued)

Study	Offense characteristics	Victim characteristics	Risk to reoffend and recidivism rates
Långström and Grann (2000)	NA	NA	No differences in general or sexual recidivism over an average 5-year follow-up.
Parks and Bard (2006)	NA	NA	No differences on PCL:YV Interpersonal and Antisocial factors, sexual recidivism, nonsexual recidivism (maximum time at risk of 11 years). MV less likely to successfully complete treatment than CV or PV. MV scored higher than CV on PCL:YV Total score, Affective and Behavioral factors, as well as JSOAP-II Impulsive-Antisocial Behavior scale, Intervention scale, and Total score. On the J-SOAP-II Sexual Drive/Preoccupation Scale, MV scored higher than CV, who scored higher than PV.
Rasmussen (1999) ^b	NA	NA	Age of youngest victim was not associated with sexual recidivism over a 5-year follow-up.
Richardson, Kelly, Bhate, and Graham (1997)	No differences in types of sexually abusive behaviors, means of overcoming victim resistance. MV had longer duration of offending than CV	PV more likely to offend against strangers. MV and CV more likely to offend against acquaintances. CV more likely to have a male victim.	NA

(continued)

Table 2. (continued)

Study	Offense characteristics	Victim characteristics	Risk to reoffend and recidivism rates
Smith and Monastersky (1986)	or PV. MV and CV engaged in a greater range of sexual acts than PV. PV more likely to commit offense in public. NA	NA	No significant difference in general or sexual recidivism.

Note: CV = Juveniles with child victims; PV = Juveniles with peer/adult victims; MV = Juveniles with mixed victim types. The following studies were excluded from this table as they did not include information relevant to either offense characteristics, victim characteristics, or risk to reoffend/recidivism: Carpenter, Peed, and Eastman (1995), Ford and Linney (1995), Hummel, Thömke, Oldenbürger, and Specht (2000), Kempton and Forehand (1992), Ronis and Borduin (2007), van Wijk and colleagues (2005, 2007), and Worling (1995).

a. Kaufman et al. (1996) did not create two categories (child vs. peer/adult). Victims divided into the following age ranges: 0-3, 4-6, 7-9, 10-12, 13-17.

b. Rasmussen (1999) did not compare based on victim age categories but used age of victim as a predictor of recidivism.

Bijleveld, 2004; van Wijk, van Horn, Bullens, Bijleveld, & Doreleijers, 2005). Research to date has found not found significant differences in externalizing symptoms between groups (‘t Hart-Kerkhoffs et al., 2009; Hendriks & Bijleveld, 2004; Kempton & Forehand, 1992; Richardson et al., 1997; Ronis & Borduin, 2007). Consistent findings that JSOs with child victims are more likely to have internalizing problems would demonstrate a potentially important difference in the etiology of offending against children that has implications for treatment planning.

Juveniles who offend against children are expected to have lower self-esteem and greater deficits in social skills than juveniles who offend against peers/adults. Although there is some support for greater problems in peer relationships among those who select child victims (Gunby & Woodhams, 2010; Hendriks & Bijleveld, 2004; Hunter et al., 2003; van Wijk, van Horn, et al., 2005), other research has not confirmed this hypothesis (Ford & Linney, 1995; Ronis & Borduin, 2007). The literature regarding differences in self-esteem is also inconsistent (Ford & Linney, 1995; Gunby & Woodhams, 2010). The inconsistent results cast doubt on the theory that poor social skills or peer relationships play a role in the etiology of offending against children, and further research is needed to clarify the mixed results to date.

Juveniles adjudicated for sexual crimes against peer/adult victims have been hypothesized to be more generally delinquent and antisocial than those who commit crimes against children. Some research demonstrates the expected difference in prior arrests (Ford & Linney, 1995; Kemper & Kistner, 2007; Richardson et al., 1997);

however, other studies have not found a significant difference (Carpenter et al., 1995; Hendriks & Bijleveld, 2004; Hunter, Hazelwood, & Slesinger, 2000) or have found the reverse (Hunter et al., 2003). A recent meta-analysis found that those with only peer/adult victims were more likely to have indicators of delinquency risk or a history of arrests than those with any child victims (Seto & Lalumière, 2010). It is somewhat difficult to interpret these findings given the lack of differences identified when externalizing symptoms are studied; it is possible that a difference in arrest history or delinquency risk factors is more likely to be detected in correctional samples, although such differences were not found in all studies with such samples. Further research is needed to clarify whether JSOs with peer/adult victims are more generally antisocial.

If juveniles who offend against peers/adults are hypothesized to be similar to general delinquents, then the characteristics commonly seen in families of delinquents may be seen in this subgroup more frequently. Family risk factors for delinquency include poor parental monitoring, punitive or inconsistent discipline, emotionally distant parents, child physical abuse, low family income (Murray & Farrington, 2010), and witnessing family violence (Zinzow et al., 2009). There is some initial evidence that those who select peer/adult victims are more likely to have been exposed to inconsistent discipline and socioeconomic deprivation (Gunby & Woodhams, 2010). Findings regarding differences in exposure to family violence (Ford & Linney, 1995; Gunby & Woodhams, 2010; Richardson et al., 1997) and exposure to family criminality (Ford & Linney, 1995; Gunby & Woodhams, 2010) are inconsistent. Seto and Lalumière's (2010) meta-analysis found no difference between these subtypes on family problems. If a consistent body of literature shows differences between subgroups in family characteristics, this would provide further evidence for the validity of the distinction between these groups. Additional research is needed given the inconsistent results to date.

Differences Consistently Found Between Victim-Age-Based Subgroups

Much of the research to date on victim-age-based subgroups focuses on subgroup differences that are not clearly tied to any theoretical expectations, yet these comparisons have produced the most consistent findings across studies. There is a variety of research suggesting that juveniles with peer/adult victims are more likely to use force or violence (Gunby & Woodhams, 2010; 't Hart-Kerkhoffs et al., 2009; Hendriks & Bijleveld, 2004; Hunter et al., 2000, 2003; cf. Richardson et al., 1997). There is also substantial evidence that juveniles with peer/adult victims are more likely than those with child victims to offend against strangers (Gunby & Woodhams, 2010; 't Hart-Kerkhoffs et al., 2009; Hendriks & Bijleveld, 2004; Hunter et al., 2000, 2003; Richardson et al., 1997). Juveniles who have any child victims (including mixed offenders) are more likely to offend against family members (Hunter et al., 2003; Kemper & Kistner, 2007) or acquaintances (Richardson et al., 1997). In addition, juveniles who have any child victims are consistently found to be more likely than those with only peer/adult

victims to have offended against at least one male (‘t Hart-Kerkhoffs et al., 2009; Hendriks & Bijleveld, 2004; Hunter et al., 2000; Kemper & Kistner, 2007; Richardson et al., 1997). Although the importance of such differences is currently unclear, demonstrating similar differences in new samples suggests some comparability to prior research.

Risk to Reoffend/Recidivism

Theories regarding victim-age-based subgroups could reasonably lead to a hypothesis that those who offend against peers/adults will have higher general recidivism rates due to higher overall antisociality; however, the research to date has not found any significant differences in general or nonsexual rearrest rates (Hagan & Cho, 1996; Kemper & Kistner, 2007; Långström & Grann, 2000; Parks & Bard, 2006; Smith & Monastersky, 1986). In addition, there is evidence that juveniles with child victims and those with mixed victims score higher than juveniles with peer/adult victims on a risk assessment instrument designed for JSOs (Parks & Bard, 2006), yet research has consistently failed to demonstrate significant differences in sexual recidivism (Hagan & Cho, 1996; Hagan, Gust-Brey, Cho, & Dow, 2001; Kemper & Kistner, 2007; Långström & Grann, 2000; Parks & Bard, 2006; Rasmussen, 1999; Smith & Monastersky, 1986). Selecting male child victims is believed to be a risk factor for sexual recidivism in JSOs (Prentky & Righthand, 2003), perhaps because research has demonstrated that sexual interest in children (Hanson & Morton-Bourgon, 2005) and selection of male child victims (Hanson & Bussière, 1998) are associated with higher recidivism rates. In addition, the selection of child victims may be perceived as indicative of increased risk for sexual recidivism because child victims are more easily intimidated or coerced and less capable of making effective reports. Therefore, a potential difference in recidivism between victim-age-based subgroups is an important area for continued study, especially given the heightened emphasis in recent years on identifying high-risk youth (e.g., Elkovitch, Viljoen, Scalora, & Ullman, 2008; Prentky, Li, Righthand, Schuler, Cavanaugh, & Lee, 2010).

Study Rationale and Aims

Although there are a number of theoretically expected differences between victim-age-based subgroups of JSOs, consistent findings (or consistent null results) have been elusive to date. The most consistent results are for differences that are not clearly connected to etiological theory, treatment outcome, or recidivism, and thus the validity of making distinctions between groups based on victim age is uncertain. Additional research is needed to provide more evidence, where results have been inconsistent to date, and to shift the focus to theoretically relevant variables.

In addition, further research is required to address the limitations of the existing research. Many studies have been limited to juveniles in residential or correctional settings (e.g., Ford & Linney, 1995; Hagan & Cho, 1996; Hagan et al., 2001; Hunter

et al., 2003; K. L. Kaufman, et al., 1996; Kemper & Kistner, 2007; Parks & Bard, 2006). Other studies have included youth not yet adjudicated for sexual offenses ('t Hart-Kerkhoffs et al., 2009; Långström & Grann, 2000). Concerns regarding the generalizability of these types of samples suggest that additional research regarding juveniles participating in outpatient treatment is needed. In addition, a number of studies do not explicitly articulate the method used to classify victims as children or peers (e.g., Graves et al., 1996; Hagan & Cho, 1996; Hagan et al., 2001; Kempton & Forehand, 1992; van Wijk, van Horn, et al., 2005). Furthermore, many studies have relied exclusively on file reviews rather than interviews or assessment measures completed by the child or parent (e.g., Gunby & Woodhams, 2010; Hunter et al., 2000; Richardson et al., 1997). The inclusion of parent-report and the use of standardized assessment measures has been a rarity to date, and most studies include relatively few of the variables described above (for an exception, see Ronis & Borduin, 2007). Finally, the majority of studies have excluded offenders with both child and peer/adult victims.

The current study seeks to build on this existing literature by comparing JSOs from an outpatient treatment sample who were classified into one of three groups based on the age(s) of their victim(s): child victims (at least 4 years younger than offender), peer/adult victims, or both types of victims (referred to as mixed). The study draws on a comprehensive database that includes a wide range of variables gathered using a variety of methods and informants (i.e., self-report, parent-report, semistructured clinical interview, and legal documentation). The study focuses first on theoretically relevant variables, as differences on these variables inform the validity of this method of subtyping juvenile offenders. Second, we will examine some of the victim characteristics commonly studied in prior research, to demonstrate the comparability of our sample with previous studies. Finally, we will examine risk and recidivism, given the importance of identifying high-risk youth.

As compared to those with peer/adult victims, juveniles with child victims were hypothesized to: 1) have higher rates of sexual victimization but not physical abuse; 2) be more likely to be diagnosed with anxiety and affective disorders, but not other mental health diagnoses; 3) have more severe symptoms of depression, anxiety, posttraumatic stress, and general internalizing problems but will not differ in symptoms of externalizing problems or anger; 4) have more peer problems and lower social competence.

Given the theory- and research-based expectations that juveniles who offend against peer/adult victims are more generally antisocial, we hypothesize that that this group will: 5) be more likely to have a history of prior arrests; 6) score higher on a measure of antisocial tendencies; 7) demonstrate more problematic scores on scales assessing parenting practices and activities; 8) have higher rates of witnessing domestic violence.

Based on prior consistent findings in the literature, we hypothesize that juveniles with child victims will: 9) be more likely to have male victims and to have offended

against a biological relative and 10) score higher on the Juvenile Sexual Offender Assessment Protocol–II (J-SOAP-II; and 11) not differ in recidivism rates.

Few studies have included offenders who have both child and peer/adult victims and a theoretical basis for making predictions regarding this group is lacking. Therefore, the current study will examine differences between this group and the other two groups of offenders in an exploratory manner, comparing groups on only those domains that have been studied in prior research with mixed offenders: mental health functioning, antisocial tendencies, victim characteristics, and recidivism.

Method

Participants

The participants in the current study included 176 males adjudicated for a sexual offense and court-ordered to participate in an outpatient treatment program. This treatment program is offered by the Services for Adolescent and Family Enrichment program at Western Psychiatric Institute and Clinic in collaboration with the Special Services Unit of the Allegheny County Juvenile Probation Department (hereafter the SAFE/SSU Program). This program has been described in detail previously (Kolko, Noel, Thomas, & Torres, 2004). Female offenders ($n = 2$) and youth with no identifiable victim (e.g., child pornography offenders, $n = 19$) were excluded from all analyses. Of the 176 youth included in this study, 114 (65%) selected only child victims, 50 (28%) selected only peer/adult victims, and 12 (7%) had mixed victims. Participants were classified into these groups based on information from legal records, rather than self-report.

The average age of the JSOs in this study was 15.27 ($SD = 1.96$) with a range from 10 years, 11 months to 19 years, 7 months. There were no significant differences between groups in age at the time of the baseline assessment, $F(2, 173) = 0.07, p = .928$. A total of 14 juveniles (8% of total sample) were age 18 or 19 at the time of their intake into the treatment program. In such circumstances, the youth committed the referral offense prior to his 18th birthday. Some data regarding race and ethnicity was not recorded ($n = 37$), but those who reported primarily indicated they were White, non-Hispanic (48%) or Black, non-Hispanic (44%). Only 1% of youth indicated Hispanic ethnicity, 1% were Asian/Pacific Islander, 4% were biracial, and 1% categorized themselves as Other. There was not a significant difference in the proportion of racial/ethnic minority youth between groups, likelihood ratio (2) = 3.64, $p = .163$. Very few participants had a prior nonsexual (9%) or sexual (0.6%, $n = 1$) conviction. Based on legal records, the juveniles in this sample had an average of 1.22 victims each, with a range from 1 to 8 and a mode of 1 (86% of juveniles). The victims of these youth ranged from 2 to 74 years of age. When using the age of the youngest victim for offenders with multiple victims, the average victim age was 9.81 years ($SD = 4.55$). The majority of juveniles had only female victims (74%), with almost a quarter

offending against only males (24%) and only 2% offending against both females and males. Very few juveniles offended against a stranger (3%), 26% offended against a biological relative, and the remainder offended against acquaintances or nonbiological relatives. A substantial minority of the participants were diagnosed upon intake (using the K-SADS-PL, see below, available for 168 participants) with a disruptive behavior disorder (41%), with 34% of the sample meeting criteria for attention deficit hyperactivity disorder, 9% for conduct disorder, and 12% for oppositional defiant disorder. Other mental health diagnoses were less common (7% met criteria for an anxiety disorder, 3% for an affective disorder, 2% for a substance use disorder). Overall, 66% of the sample met diagnostic criteria for at least one mental health diagnosis.

Program Orientation and Assessment Procedures

Juveniles adjudicated for a sexual offense were referred to the SAFE/SSU treatment program based on a judge's decision that the juvenile required sex offender-specific treatment and could be treated safely in the community. Each family was invited to participate in a separate, completely voluntary research protocol which was approved by the University of Pittsburgh Institutional Review Board. Both parental consent and youth assent were required for use of the data for research purposes. The intake and discharge assessments were part of the routine treatment protocol and were completed by all juveniles who entered treatment. Follow-up assessments were conducted solely for research purposes for the 2 years following treatment discharge. The juvenile and caregiver received compensation for participating in all assessments (US\$10 each at intake, US\$20 each at discharge and both 1-year and 2-year follow-up assessments).

Measures

Participants in the study completed a wide range of measures (see Kolko et al., 2004). Only those used in the current analysis are reviewed here.

Abuse history. To address Hypothesis 1, we used information about participants' history of maltreatment as drawn from several sources.

Items from the Schedule for Affective Disorders and Schizophrenia for School Aged Children—Present and Lifetime Version (K-SADS-PL). When clinicians completed the K-SADS-PL (J. Kaufman, Birmaher, Brent, Rao, & Ryan, 1996) section on PTSD (see detailed description of K-SADS-PL below), they first provided a present/absent rating for a variety of traumatic experiences, including physical abuse, sexual abuse, and witnessing domestic violence. This rating was made independently of ratings of posttraumatic stress symptoms. This was the most inclusive (i.e., had least missing data) of all measures that assessed child maltreatment. We rated each type of maltreatment as present if the clinician indicated the experience happened based on their interview of either the parent or the child. Ratings regarding whether the juvenile witnessed domestic violence will be used to address Hypothesis 8.

Items from the Adolescent Clinical Sexual Behavior Inventory (ACSBI). In addition, parent- and self-report will be examined based on specific items from the ACSBI (Friedrich, Lysne, Sim, & Shamos, 2004). The ACSBI “was designed for use in a clinical sample to assess sexual risk taking, nonconforming sexual behaviors, sexual interest, and sexual avoidance/discomfort” (Friedrich et al., 2004, p. 241). In three individual items on the ACSBI (Items 47, 48, and 49), participants and their parents were asked to rate the likelihood the participants experienced physical, sexual, and emotional abuse on a scale from 0 (*not likely*) to 4 (*definitely*). These scores were dichotomized into *no abuse* (score of 0) or *possible abuse* (score of 1 to 4) based on parent report and child report separately.

Mental health. Several sources will be used to test Hypotheses 2 and 3, including mental health diagnoses as well as symptom rating scales.

Mental health diagnoses based on K-SADS-PL. Diagnoses were made at the time of intake based on the K-SADS-PL (J. Kaufman, et al., 1996), a semistructured interview designed to assist in the assessment of major mental disorders in school aged children. Clinicians made diagnoses based on information from both the child and parent, as well as any collateral information available. The K-SADS-PL has been demonstrated to have concurrent validity and excellent interrater and test-retest reliability (Kaufman et al., 1997).

Symptom severity, Trauma Symptom Checklist for Children (TSCC). In addition, juveniles completed the TSCC (Briere, 1996). The TSCC was developed to provide a self-report evaluation of current trauma-related symptoms or distress in children and adolescents (ages 8-16) who have been exposed to unspecified traumatic events. The TSCC was standardized on a large sample of diverse children and provides norms according to age and gender, as well as clinical cutoff scores. In general, studies of the TSCC have demonstrated good internal consistency, concurrent validity, and predictive validity (Lanktree & Briere, 1995; Sadowski & Friedrich, 2000). The sample included 35 participants above age 16, for whom scores were derived using the age 16 norms. There are no hypotheses for two scales (Dissociation and Sex Concerns), but they are included for exploratory purposes. In addition, given the high likelihood of underreporting by many juveniles participating in intake evaluations for a court-ordered treatment program, scores on the Underreporting scale of the TSCC will also be investigated.

Symptom severity, Child Behavior Checklist (CBCL)/Strengths and Difficulties Questionnaire (SDQ). The child’s primary caretaker completed either the CBCL (Achenbach & Rescorla, 2001) or the SDQ (Goodman, 1997). The CBCL provides a dimensional assessment of an array of behavioral and emotional problems and competencies (Achenbach & Rescorla, 2001). This instrument has been used in a multitude of studies, with strong support for its utility (Achenbach, 2005). In this study, only the higher order scales of externalizing and internalizing symptoms are used. For 35 participants, the CBCL was replaced by the briefer SDQ. The SDQ also yields a comprehensive set of ratings regarding the severity of the child’s clinical problems and competencies. These two instruments have demonstrated similar accuracy in screening for psychiatric disorders, with good sensitivity and specificity in identifying disruptive behavior

disorders (Warnick, Bracken, & Kasl, 2008), and scores on the externalizing and internalizing problems scales on the SDQ are highly correlated with the equivalent scores on the CBCL ($r = .84$, $r = .74$, respectively; Goodman & Scott, 1999). Therefore, to include as much data as possible, the CBCL Externalizing and Internalizing T -scores and the SDQ Externalizing and Internalizing raw scores were each standardized, and whichever standardized score was available was used. Although these variables are not equivalent given that the T -score is based on normative data, this was considered the most useful way to include all of the data.

Social skills. To test Hypothesis 4, information regarding social competence and peer problems were drawn from two measures.

Social competence. For those youth whose parents completed the CBCL, groups are compared on the Social Competence scale. The Prosocial scale of the SDQ was not combined with the Social Competence scale due to significant differences in item content.

Social/peer problems. In addition, as was done regarding the externalizing and internalizing scales, the CBCL Social Problems and the SDQ Peer Problems scales were standardized and then combined into one variable. These two scales are moderately highly correlated ($r = .59$; Goodman & Scott, 1999).

Criminal history/antisocial tendencies. Legal records of prior arrests and scores on the Antisocial Process Screening Device will be used to address Hypotheses 5 and 6.

Prior arrests. The intake packet includes information about prior court involvement and any prior arrests. A dichotomous variable reflecting any prior arrest will be used rather than a continuous measure of number of arrests because the vast majority of youth had either zero or one prior arrest.

Antisocial Process Screening Device (APSD). The APSD (Frick & Hare, 2001) was developed to assess psychopathy-related characteristics in young children based on parent ratings. The measure includes 20 items (0-2 scale) that form three factors (callous/unemotional traits, narcissism, impulsivity; Frick, Bodin, & Barry, 2000). The measure has acceptable psychometric properties, including test-retest reliability, internal consistency, and concurrent and predictive validity (e.g., Frick et al., 2000; Poythress, Dembo, Wareham, & Greenbaum, 2006). This measure has been standardized in a large sample of community youth (Frick et al., 2000). The APSD manual indicates that the instrument is designed for youth aged 6 to 13, but prior research has demonstrated acceptable psychometric properties of the self- and parent-report versions of this measure to assess youth up to age 21 (e.g., Bijttebier & Decoene, 2009; Kruh, Frick, & Clements, 2005; Muñoz & Frick, 2007; Sadeh, Verona, Javdani, & Olson, 2009).

Family functioning/parenting practices. To test Hypothesis 7, the Alabama Parenting Questionnaire (APQ; Shelton, Frick, & Wootton, 1996) was used to gather information about family functioning. The APQ is a parent-reported measure and evaluates six common dimensions of parenting practices and activities (e.g., involvement, positive parenting, corporal punishment) related to antisocial behavior. The APQ has demonstrated good internal consistency and construct validity in a variety of cultures (e.g., Dadds, Maujean, & Fraser, 2003; Essau, Sasagawa, & Frick, 2006; Shelton et al., 1996).

Victim characteristics. Victim characteristics, including the gender of victims and the presence of a biological relationship between victim and offender, were coded from legal documentation provided by the court to test Hypothesis 9.

Risk to reoffend/recidivism. To test Hypotheses 10 and 11, data from the J-SOAP-II and from legal records regarding rearrest were used.

J-SOAP-II. A small subset of the participants ($n = 32$; 21 with child victims, 9 with peer/adult victims, 2 with mixed victims) were scored on the J-SOAP-II (Prentky & Righthand, 2003) at treatment intake. The J-SOAP-II has evidence of reliability and construct validity, although further research is needed to establish predictive validity for sexual reoffending (Caldwell & Dickinson, 2009; Caldwell, Ziemke, & Vitacco, 2008; Elkovitch et al., 2008; Martinez, Flores, & Rosenfeld, 2007; Parks & Bard, 2006; Prentky, Harris, Frizell, & Righthand, 2000; Prentky et al., 2010; Righthand, Prentky, Knight, Carpenter, Hecker, & Nangle, 2005; Viljoen et al., 2008). Given the small number of youth with J-SOAP-II scores available, only the total score will be examined.

Rearrest. At the time of this analysis, 149 of the 176 youth included in this study had been discharged from the treatment program, and recidivism data were available for 102 juveniles. Recidivism data were collected from official juvenile court records at approximately the same time as the follow-up evaluations (1 year and 2 years after discharge from the program). Recidivism data were unavailable for 47 youth, either because they had not reached the 1-year follow-up time point or their records were not able to be located. Overall, 15% of participants had any posttreatment arrests and 2% had any posttreatment arrests for sexual offenses. Information about subsequent incarceration or treatment in residential facilities was not available; therefore, recidivism analyses do not account for time at risk in the community.

Data Analysis

Juveniles with child victims and those with peer/adult victims were compared first, followed by a more limited set of analyses comparing both groups with those with mixed victims. Comparisons between juvenile with child victims and those with peer/adult victims were made using chi-square analyses to test for differences in categorical variables, and t tests were used to test for differences in continuous variables. In all analyses involving continuous variables, Levene's test of homogeneity of variance was first examined; if significant, the t test with equal variances not assumed was used. The Levene's test is only reported if it indicated significantly different variance between groups. The current study is quite exploratory in nature, despite the reliance on past research to select variables of interest. As a result, a large number of comparisons are made, increasing the risk of Type I error. Therefore, significance values below .01 will be considered significant rather than the more traditional .05 significance value. Significance will be indicated at the .05 level for the Levene's test of homogeneity of variance to ensure that appropriately conservative tests are used.

Analyses that included all three subgroups (those with child victims, peer/adult victims, and mixed victims) used ANOVA for continuous variables and the likelihood ratio test for categorical variables, which is more appropriate than a chi-square test when at least one cell of the analysis has an expected value less than 5 (Field, 2009).

Results

Juveniles With Child Victims Compared With Juveniles With Peer/Adult Victims

Abuse history. There were no significant differences between groups on self- or parent-reported physical, sexual, or emotional abuse based on the ACSBI abuse items or based on clinicians' ratings of the presence of each type of maltreatment on the K-SADS-PL (see Table 3). There is a nonsignificant trend for the parents of juveniles with child victims to report that their child was a victim of sexual abuse on the relevant ACSBI item more often than the parents of juveniles with peer/adult victims.

Mental health. There were no significant differences between juveniles with child victims and juveniles with peer/adult victims on any mental health variables (see Table 3). Juveniles with child victims were marginally more likely to have an anxiety disorder diagnosis, and juveniles with peer/adult victims were marginally more likely to have a substance use disorder. In addition, juveniles with child victims scored marginally higher on the Depression scale of the TSCC.

Social skills. There were no significant differences between groups on the Social Competence scale of the CBCL or on the combined CBCL/SDQ variable indicating social/peer problems (see Table 3).

Criminal history/antisocial tendencies. There were no significant differences between groups on any indicators of criminal history or antisocial tendencies (see Table 3).

Family functioning/parenting practices. There was a significant difference between groups on poor monitoring on the APQ. The parents of juveniles with peer/adult victims reported greater problems in monitoring than the parents of juveniles with child victims. There were no other significant differences between groups on family functioning or parenting practices. Clinicians indicated that juveniles with child victims had witnessed domestic violence at a marginally higher rate than juveniles with peer/adult victims.

Victim characteristics. There were significant differences between groups on both victim characteristics studied: any male victims and any biological relative victims (see Table 3). Juveniles with child victims were more likely to have a male victim and more likely to have a biologically related victim.

Risk to reoffend/recidivism. There was not a significant difference between groups on J-SOAP-II total score (see Table 3). There was not a significant difference in rearrest for sexual offenses, but there was a difference in general recidivism rates, with juveniles with peer/adult victims having a higher rearrest rate than juveniles with child victims.

Table 3. Comparisons Between Juveniles With Child Victims and Those With Peer/Adult Victims

	Child victim group	Peer/adult victim group	df	Statistic	p
	M (SD) or % (n)	M (SD) or % (n)			
Abuse history					
Clinician's indication that child maltreatment occurred (K-SADS)					
Physical abuse	22.94% (25)	17.78% (8)	1	$\chi^2 = 0.50$	.478
Sexual abuse	17.59% (19)	8.89% (4)	1	$\chi^2 = 1.88$	.170
Child's report on ACSBI Items 47, 48, 49					
Physical abuse	21.36% (22)	15.91% (7)	1	$\chi^2 = 0.58$	.447
Sexual abuse	15.53% (16)	6.82% (3)	1	$\chi^2 = 2.08$	.149
Emotional abuse	33.33% (34)	20.45% (9)	1	$\chi^2 = 2.45$	.117
Parent's report on ACSBI Items 47, 48, 49					
Physical abuse	21.51% (20)	19.05% (8)	1	$\chi^2 = 0.11$	.744
Sexual abuse	29.03% (27)	9.76% (4)	1	$\chi^2 = 5.95$	.015
Emotional abuse	55.91% (52)	47.62% (20)	1	$\chi^2 = 0.80$	.371
Mental health					
Diagnoses based on K-SADS-PL					
Disruptive behavior disorder	38.53% (42)	44.68% (21)	1	$\chi^2 = 0.52$	.473
Anxiety disorder	10.09% (11)	0% (0)	1	$\chi^2 = 5.10$	.035°
Affective disorder	3.67% (4)	2.13% (1)	1	$\chi^2 = 0.25$	1.00°
Substance use disorder	0% (0)	6.38% (3)	1	$\chi^2 = 7.09$	.026°
Trauma Symptom Checklist for Children					
Anxiety	47.06 (8.43)	46.45 (6.61)	143	t = 0.42	.673
Depression	48.06 (8.55)	45.16 (5.82)	143	t = 2.05	.042
Anger	45.19 (7.59)	44.98 (6.91)	143	t = 0.16	.875
Posttraumatic stress	48.60 (8.92)	46.45 (7.55)	143	t = 1.40	.165
Dissociation	47.50 (7.90)	45.39 (6.42)	143	t = 1.56	.121
Sex concerns ^a	48.79 (11.14)	46.68 (8.70)	103.60	t = 1.23	.222
Underreporting	53.86 (11.78)	55.80 (12.08)	143	t = -0.90	.368
Child Behavior Checklist/Strengths and Difficulties Questionnaire					
Internalizing	0.05 (0.96)	-0.10 (1.09)	149	t = 0.83	.409
Externalizing	-0.09 (1.03)	0.19 (0.92)	149	t = -1.63	.106
Social skills					
CBCL social competence ^b	40.13 (9.05)	42.37 (7.25)	89.63	t = -1.44	.154
CBCL/SDQ		-0.09 (1.04)	149	t = 0.80	.426
Social/peer problems	0.05 (0.94)				
Criminal history/antisocial tendencies					
Any prior nonsexual arrests	6.36% (7)	14.89% (7)	1	$\chi^2 = 2.95$	.123°
Antisocial Process Screening Device					
Callous/unemotional	3.91 (2.20)	4.18 (2.24)	136	t = -0.67	.505
Narcissism	3.79 (3.13)	3.77 (2.43)	136	t = 0.04	.967
Impulsivity	4.36 (2.19)	4.95 (1.84)	136	t = -1.55	.123

(continued)

Table 3. (continued)

	Child victim group	Peer/adult victim group	df	Statistic	p
	M (SD) or % (n)	M (SD) or % (n)			
Family functioning/parenting practices					
Alabama Parenting Questionnaire					
Involvement	37.88 (5.30)	36.74 (5.78)	116	$t = 1.04$	.302
Positive parenting	24.71 (3.61)	24.33 (3.27)	116	$t = 0.536$	.593
Poor monitoring	16.74 (5.14)	20.77 (5.02)	115	$t = -3.88$	<.001
Inconsistent discipline	13.95 (3.98)	14.09 (3.95)	116	$t = -0.17$	.867
Corporal punishment	4.42 (2.15)	4.76 (2.22)	114	$t = -0.78$	.438
Clinician's indication that child maltreatment occurred (K-SADS)					
Witnessed domestic violence	46.73% (50)	26.67% (12)	1	$\chi^2 = 5.28$	.022
Victim characteristics					
Any male victim	35.09% (40)	8.00% (4)	1	$\chi^2 = 12.99$	<.001
Victim was biological relative	37.50% (42)	6.00% (3)	2	$\chi^2 = 17.10$	<.001
Risk to reoffend/recidivism					
J-SOAP-II Total score	21.50 (6.90)	18.22 (6.80)	28	$t = 1.20$	.240
Any rearrest	7.94% (5)	30% (9)	1	$\chi^2 = 7.74$	.011 ^a
Sexual rearrest	0% (0)	3.33% (1)	1	$\chi^2 = 2.12$	.323 ^b

Note: K-SADS-PL = Schedule for Affective Disorders and Schizophrenia for School Aged Children—Present and Lifetime Version, ACSBI = Adolescent Clinical Sexual Behavior Inventory, APSD = Antisocial Process Screening Device, TSCC = Trauma Symptom Checklist for Children, CBCL = Child Behavior Checklist, SDQ = Strengths and Difficulties Questionnaire, APQ = Alabama Parenting Questionnaire, J-SOAP-II = Juvenile Sex Offender Assessment Protocol-II. ^aFisher's Exact Test used because at least one cell has an expected count less than 5. Maximum scores on the APSD scales are 14 for Narcissism, 10 for Impulsivity, and 12 for Callous-Unemotional. TSCC scores are *T*-scores ($M = 50$). CBCL/SDQ Internalizing, Externalizing, and Social/Peer Problems are *z* scores. CBCL Social Competence score is a *T*-score ($M = 50$). Maximum scores on the APQ scales are 50 for Involvement, 30 for Positive Parenting, 50 for Poor Monitoring, 30 for Inconsistent Discipline, and 15 for Corporal Punishment.

a. Levene's test $F = 4.15$, $p = .044$.

b. Levene's test $F = 4.16$, $p = .044$.

Comparisons Including All Three Subgroups

Mental health. There were no significant differences between groups in rates of mental health diagnoses when juveniles with mixed victims were included in analyses (see Table 4). There were marginal differences in rates of anxiety disorder and substance use disorder. In both categories of diagnosis, juveniles with mixed victims appeared to be more similar to juveniles with child victims than those with peer/adult victims.

Criminal history/antisocial tendencies. There were no significant differences between groups on rates of previous arrests or scores on the APSD (see Table 4).

Victim characteristics. Differences in rates of offending against males and against biological relatives remained significant when mixed offenders were included in the analyses (see Table 4). Juveniles with mixed victims appeared more similar to those with peer/adult victims in victim selection.

Recidivism. There was a marginal difference between groups in general rearrest rates, with juveniles with peer/adult victims having the highest rate of general rearrest. There was not a significant difference in sexual rearrest rates.

Discussion

In a sample of juveniles adjudicated for sexual offenses mandated to an outpatient treatment program, a comparison of subgroups based on the ages of their victim(s) revealed more similarities than differences. The few differences identified, however, were consistent with hypotheses drawn from theory and prior research. The results relevant to each hypothesis will be discussed in the context of the existing literature. The study's limitations and clinical implications will also be addressed.

There were no significant group differences in rates of sexual victimization, which was contrary to Hypothesis 1 but not unprecedented (t Hart-Kerkhoffs et al., 2009; Hendriks & Bijleveld, 2004; Ronis & Borduin, 2007). There are several possible explanations for this. First, Worling (1995) noted that juveniles who offend against male children are more likely than other juveniles to have a history of sexual victimization. The current sample included relatively few youth with male victims, perhaps limiting the ability to detect such a difference. Second, it is possible that sexual abuse serves as a risk factor for engaging in sexually abusive behaviors in general rather than specifically for committing offenses against children (e.g., Johnson & Knight, 2000; Seto et al., 2010; Sigurdsson, Gudjonsson, Asgeirsdottir, & Sigfusdottir, 2010). Consistent with this hypothesis, the rate of experiencing child sexual abuse was higher across groups than that found in general population males (7.5% lifetime prevalence; Finkelhor, Turner, Ormrod, & Hamby, 2009) regardless of informant (12% based on child report, 14% based on clinician ratings that abuse occurred, 24% based on parent report). The marginal effect regarding sexual victimization based on parent report may be the result of parents reporting that their child may have been abused because it is a potential explanation for their child's behavior rather than because they are aware of a specific incident of sexual abuse. Indeed, of the parents who indicated possible sexual abuse, only 34% indicated their child was "definitely" abused, with the majority indicating that such abuse might have happened. Overall, the current results do not support theories that postulate a major role for childhood sexual victimization in the development of sexual offending against children (e.g., Hall & Hirschman, 1992; Seto & Lalumière, 2010; Ward & Siebert, 2002), although findings from previous research suggest this variable may be important (Seto & Lalumière, 2010).

Contrary to Hypotheses 2 & 3, there were no significant differences between groups in mental health problems, including internalizing symptoms and disorders. There was a marginal difference in rates of anxiety disorder diagnosis, and it is notable that no juveniles with peer/adult victims met criteria for an anxiety disorder. Unexpectedly, there was also a marginal difference in rates of substance use disorder, and again, although not significant, it is notable that no juveniles with child victims met criteria

Table 4. Select Comparisons of Juveniles With Child Victims, Peer Victims, and Both Types of Victims

	Child victim group	Peer/adult victim group	Mixed age victim group			
	<i>M</i> (<i>SD</i>) or % (<i>n</i>)	<i>M</i> (<i>SD</i>) or % (<i>n</i>)	<i>M</i> (<i>SD</i>) or % (<i>n</i>)	<i>df</i>	Statistic	<i>p</i>
Mental health diagnoses based on K-SADS-PL						
Disruptive behavior disorder	38.53% (42)	44.68% (21)	50.00% (6)	2	LR = 0.93	.627
Anxiety disorder	10.09% (11)	0% (0)	8.33% (1)	2	LR = 8.27	.016°
Affective disorder	3.67% (4)	2.13% (1)	0% (0)	2	LR = 1.02	.599°
Substance use disorder	0% (0)	6.38% (3)	0% (0)	2	LR = 7.79	.020°
Criminal history/antisocial tendencies						
Any prior nonsexual arrests	6.36% (7)	14.89% (7)	8.33% (1)	2	LR = 2.73	.255
Antisocial process screening device						
Callous/unemotional	3.91 (2.20)	4.18 (2.24)	3.58 (2.61)	(2, 147)	<i>F</i> = 0.40	.670
Narcissism	3.79 (3.13)	3.77 (2.43)	4.75 (3.11)	(2, 147)	<i>F</i> = 0.60	.552
Impulsivity	4.36 (2.19)	4.95 (1.84)	4.67 (1.97)	(2, 147)	<i>F</i> = 1.23	.295
Victim characteristics						
Any male victim	35.09% (40)	8.00% (4)	8.33% (1)	2	LR = 13.04	<.001
Victim was biological relative	37.5% (42)	6.00% (3)	8.33% (1)	2	LR = 23.23	<.001
Recidivism						
Any rearrest	7.94% (5)	30.00% (9)	11.11% (1)	2	LR = 7.33	.026°
Sexual rearrest	0% (0)	3.33% (1)	11.11% (1)	2	LR = 4.64	.098°

Note: LR = Likelihood Ratio statistic, used when ≥ 1 cell had an expected count less than 5. K-SADS-PL = Schedule for Affective Disorders and Schizophrenia for School Aged Children—Present and Lifetime Version, APSD = Antisocial Process Screening Device. Maximum scores on the APSD scales are 14 for Narcissism, 10 for Impulsivity, and 12 for Callous-Unemotional.

for a substance use disorder. Prior research on mental health differences between juveniles with child victims and those with peer/adult victims has been mixed, although there is more support for differences in internalizing than externalizing problems. The lack of significant differences in externalizing symptoms and disorders in the current study is consistent with Hypothesis 3 as well as prior research on externalizing symptoms (Kavoussi, Kaplan, & Becker, 1988), in that overall rates of disruptive behavior disorder diagnosis were high (with general population prevalence rates of ODD and CD being estimated at 3.2% and 3.3%: Canino, Polanczyk, Bauermeister, Rohde, & Frick, 2010; 3.3% prevalence rates for ADHD: Polanczyk et al., 2010), but there were

no differences between groups on externalizing symptoms or diagnoses. The implications of potential differences in mental health problems between groups for theories positing a role for psychopathology in the development of sexual offending against children is unclear as all research that has studied this question, including the present study, relied on assessments made after the offense occurred. Nonetheless, there is a pattern across studies suggesting greater anxiety and internalizing problems in juveniles with child victims, which suggests that internalizing symptoms may be more likely to be a focus of treatment in this subgroup.

There were no significant differences between groups on peer problems and social competence in the current study, contrary to Hypothesis 4, and prior research on this topic is mixed. Social skills training is commonly included in treatment programs for adolescents (used by 94% of community and 99% of residential programs; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). Such treatment may be justified by a possible link to recidivism in juvenile populations (Kenny, Keogh, & Seidler, 2001; although not in adult sex offenders, Mann et al., 2010), but given the inconsistency of research on this topic to date, there is little basis for assuming that juveniles with child victims have a greater need for such treatment than those with peer/adult victims.

Based on theory and research on both juveniles (e.g., Seto & Lalumière, 2010) and adults (e.g., Harris et al., 2009; Olver & Wong, 2006), we hypothesized that juveniles with peer/adult victims would be more generally antisocial than those with child victims (Hypotheses 5 and 6). The current study did not detect any differences between groups in past arrests or in antisocial tendencies; however, very few participants had a history of arrests. It is possible that juveniles with more arrests were considered too dangerous for outpatient treatment, resulting in a highly selected, low-risk sample. If this is the case, the low scores on the APSD in the current sample would also be expected, and thus the lack of significant differences should be interpreted very cautiously. If further research supports the hypothesis that juveniles with peer/adult victims are more generally antisocial (e.g., Seto & Lalumière, 2010), the application of empirically supported interventions designed for the treatment of general delinquency, such as multisystemic therapy (MST) and functional family therapy (e.g., Henggeler & Sheidow, 2003), may be especially effective in the treatment of juveniles with peer/adult victims. Such approaches may prove useful with all JSOs regardless of victim type, given research that suggests all JSOs have similarities to general delinquents (e.g., Ronis & Borduin, 2007; van Wijk, Loeber, et al., 2005) and given that MST has been shown to be efficacious in treating JSOs (e.g., Letourneau et al., 2009). Alternatively, outpatient samples like those in the current study may have relatively little in common with general delinquent samples, given the rarity of prior arrests and low scores on a measure of antisocial tendencies. Less intensive interventions may therefore be warranted, and empirically supported treatments for low-risk delinquents may prove useful.

The current study found only one significant difference on a standardized measure of parenting practices consistent with Hypothesis 7: the parents of juveniles with peer/

adult victims reported more problems in monitoring their children. Poor monitoring has been associated with general delinquent activity in a variety of research (e.g., Hoeve et al., 2009); the current findings suggest it might play a similar role in sex offenses committed against peers/adults. Recent longitudinal research has found that active efforts to monitor adolescents' behavior has no effect on future delinquency, suggesting that previous results may be more indicative of the effect of youth disclosure rather than active monitoring activities (Kerr, Stattin, & Burk, 2010). Nonetheless, changes in parenting practices have been shown to partially mediate the effect of MST on reoffense in general delinquent offenders (Huey, Henggeler, Brondino, & Pickrel, 2000) as well as problematic sexual behaviors in a sample of JSOs (Henggeler et al., 2009). Thus, despite current controversies in the field regarding parental monitoring efforts, treatment focused on parenting practices is likely to improve outcomes for JSOs. This may be particularly important for juveniles with peer/adult victims; however, treatment that includes the family has been shown to be effective for mixed samples of JSOs (e.g., Borduin, Schaeffer, & Heiblum, 2009; Letourneau et al., 2009; Worling & Curwen, 2000), therefore family functioning is an appropriate treatment target regardless of victim type.

Contrary to Hypothesis 8, there was not a significant difference between groups in rates of witnessing domestic violence. Furthermore, the marginal effect suggested that those with child victims, rather than those with peer/adult victims, had somewhat higher rates of this experience. Potential explanations for an association between witnessing domestic violence and offending against children are not clear, however, and further research is needed to clarify the role of this experience. In addition, it is notable that there were high rates of witnessing domestic violence and emotional abuse (parent reported) across groups. The rates of these forms of maltreatment in the current sample (47% and 56%, respectively) appear markedly higher than in the general population, as 20.3% of a large, nationally representative sample reported witnessing a family assault and 10.9% reported experiencing emotional abuse (Finkelhor, Turner, Ormrod, & Hamby, 2009). Witnessing domestic violence and experiencing emotional abuse both have been shown to have serious long-term consequences for children (e.g., Chan & Yeung, 2009; Kitzmann, Gaylord, Holt, & Kenny, 2003; Spinhoven et al., 2010; van Harmelen et al., 2010). Witnessing domestic violence is a risk factor for general delinquent behavior (e.g., Zinzow et al., 2009) and has been found to be a risk factor for sexual coercion in a community sample (Sigurdsson et al., 2010). Experiencing emotional abuse has also been shown to be associated with sexual aggression perpetration (among females) and victimization (among males; Zurbriggen, Gobin, & Freyd, 2010). Future research on JSOs should include these forms of child maltreatment, given their potentially important etiological role and the relative dearth of research on each in the JSO literature. In addition, in providing treatment for the child's own traumatic experiences, clinicians should explore potential traumatization subsequent to witnessing family violence and experiencing emotional abuse, just as for sexual and physical abuse.

Consistent with prior research and with Hypothesis 9, juveniles with child victims were more likely to offend against biological relatives and males than juveniles with peer/adult victims. Neither of these differences support any particular theoretical explanation of the etiology of sexually abusive behaviors nor are there clear indications that such victim characteristics are associated with unique risks or needs that should be addressed in treatment. These victim characteristics may reflect situational factors (e.g., ease of access to young family members) rather than indicating anything particular about the offender in question. Additional research is needed to clarify the significance of these differences in victim characteristics and to determine whether they merit different treatment approaches.

There were no differences in J-SOAP-II scores in the current study, in contrast to prior research and Hypothesis 10. Very few participants had been scored on the J-SOAP-II, and therefore this may be due to lack of power rather than a lack of true differences between groups. In contrast to Hypothesis 11, juveniles with peer/adult victims had higher general rearrest rates than those with child victims. This difference is consistent with the hypothesis that juveniles who select peer/adult victims are more generally antisocial than those who select child victims, but no other studies to date have found higher general recidivism rates among juveniles with peer/adult victims (see Table 2). Thus, there is not sufficient basis to assume this group presents greater risk. The lack of significant differences in sexual recidivism is consistent with prior research directly comparing subtypes; however, a meta-analysis found that offending against any victims significantly different in age (i.e., any victim other than a peer) was associated with sexual recidivism (McCann & Lussier, 2008). As most studies, including the current one, did not separate juveniles with adult victims from those with peer victims, existing comparisons may underestimate the relevance of victim age for recidivism risk. Based on existing research, there is little reason to recommend that one group receive more intensive treatment or be subject to more restrictive social control policies than another.

Comparisons including offenders with both types of victims were included for exploratory purposes, focusing on characteristics that have been included in previous research. The results indicate that those with mixed victims appear similar to offenders with child victims in some respects (e.g., mental health diagnoses) and appear more similar to offenders with peer/adult victims in other respects (e.g., victim characteristics). We were unable to examine some characteristics that appear specific to those with mixed victims based on prior research (e.g., those with mixed victims have been found to have an earlier age of onset and longer duration of offending than both other groups; Richardson et al., 1997). More research is needed, with larger samples of mixed offenders, before conclusions can be drawn regarding this group.

Clinical Implications

In low-risk outpatient samples, juveniles may be quite similar in their maltreatment experiences, antisocial tendencies, mental health functioning, family functioning, and recidivism risk regardless of victim type and thus may benefit from participation in

largely similar intervention programs. Existing research indicates that these interventions should be based in a cognitive-behavioral (e.g., Worling & Curwen, 2000) or multisystemic approach (e.g., Borduin et al., 2009; Letourneau et al., 2009). It is likely that low-risk outpatient samples similar to this one would benefit from MST, but it seems important to empirically examine whether less intensive interventions based on parallel treatment methods or principles would be comparably efficacious with this population. Among all JSOs, posttraumatic stress symptoms, histories of child maltreatment, and exposure to negative parenting may be a focus of clinical attention in the case of a given adolescent. It is possible that adolescents with child victims could benefit from additional programming to address the motivation for targeting children and from cognitive behavioral interventions targeting symptoms of depression and anxiety. In contrast, interventions focused on improved family functioning, including increased parental monitoring, may be particularly beneficial for adolescents with peer/adult victims. As noted above, however, such treatment may benefit all JSOs, as improved family functioning has been shown to reduce recidivism, out-of-home placements, and inappropriate sexual behaviors in general samples of JSOs (e.g., Borduin et al., 2009; Letourneau et al., 2009). For all adolescents, treatment should be individualized to address the risks and needs presented by each juvenile. It is not clear that the selection of a particular type of victim is indicative of unique risks and needs, and thus victim selection may not have a major influence on treatment planning in low-risk outpatient samples.

Limitations

The current study has several limitations. First, the sample includes only youth who were considered appropriate for outpatient treatment. Low-risk, community-treated youth have been studied less often than those in residential or correctional settings; therefore, although the results of the current study may not generalize to higher risk samples, the study provides important information about juveniles treated in community contexts. Another limitation, possibly related to the first, is the small number of mixed offenders included in the current sample. Individuals with both types of victims may have been perceived to present a greater risk and may have been ordered into a secure treatment setting more frequently than to outpatient treatment. The current study is not able to draw any firm conclusions about mixed offenders given how few were present in the sample. Third, much of the information included in this study relied on self- or parent-report. The youth and their families may have been motivated to underreport problem behaviors, as they were hoping for a short course of treatment and seeking to avoid any negative consequences from disclosure (e.g., a report to child protective services of a new victim). About 20% of the sample scored in the clinically significant range on the Underreporting scale of the TSCC. Underreporting could have limited the ability of the current study to detect true differences, particularly in mental health variables, although this is notably also the case for the majority of research on JSO subgroups. Fourth, it is impossible to determine based on the current data whether mental health symptoms and diagnoses existed prior to adjudication

(i.e., at the time of the offense) or developed subsequent to adjudication. Differences that exist at the time of the offense could be related to the etiology of the offending behaviors, whereas the importance of differences that emerge later is unclear. A fifth limitation of the current study is the presence of missing data. Using data from a program that has treatment delivery (rather than research) as a primary goal may be associated with such missing data, as other interests must take priority at times. There is no reason to suspect that one group was less likely to complete any particular measure than another group. Some measures were changed over time to serve the needs of the treatment program (e.g., to shorten intake assessments, the SDQ replaced the CBCL). Thus, the missing data are not likely to create any bias in the current results. Finally, the current study is unable to control for time at risk in the community in the analysis of recidivism and only includes juvenile referrals in Allegheny County. Some juveniles may have remained in facilities for the majority or the entirety of the follow-up period, giving them little or no opportunity to reoffend. Some may have reached the age of majority before reoffending, with the resulting charge being processed in criminal, rather than juvenile, court or may have offended in another jurisdiction. Results regarding recidivism should thus be interpreted particularly cautiously.

Conclusions and Future Directions

Overall, few of the theoretically based hypotheses regarding differences between these subtypes were supported in the current study. Combined with the inconsistent results of previous research, the current study casts doubt on the validity of theories hypothesizing differences between victim-age-based subgroups, at least as applied in a low-risk outpatient setting. This distinction has proven meaningful in adult offenders, but the current study adds to a literature that does not consistently demonstrate that these subgroups are different on psychologically meaningful variables.

Several future research directions follow from the relative lack of significant differences between victim-age-based subgroups. First, research on these subgroups has been limited by the reliance on selected samples. A large court-based study that includes juveniles who present a wide range of backgrounds, risk levels, and dispositions would enable a more definitive determination of differences between groups. Such research should include standardized measures assessing theoretically relevant constructs. Such research would provide a more definitive test of theories regarding differences between these subtypes. Second, the lack of consistency of findings regarding victim-age-based subgroups suggests that other methods of subtyping may prove more meaningful, such as using criminal history (e.g., Butler & Seto, 2002; Chu & Thomas, 2010) or personality measures (e.g., Smith, Monastersky, & Deisher, 1987; Worling, 2001). Further research on subtypes may be more productive if these methods, rather than a continued focus on victim type, are used. Finally, future research should focus on whether risk-assessment measures function differently in different subgroups (Rajlic & Gretton, 2010) and whether subgroups demonstrate a differential response to treatment as in research conducted with children with sexual behavior

problems (Pithers, Gray, Busconi, & Houchens, 1998). Such research has the potential to more directly demonstrate the treatment needs of these juveniles, improve risk assessment methods, and enhance treatment practices with this population.

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Young people with harmful sexual behaviour: Do those with learning disabilities form a distinct subgroup?

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Abstract *The study examines 102 young people with Learning Disabilities ($n = 51$) and without a learning disability (NLD; $n = 51$) to explore ways in which LD young people with harmful sexual behaviours (HSB) should be recognized as a subgroup requiring specialized treatment and intervention. Throughout this comparison of perpetrator, victim and abuse characteristics the similarities between the two groups are confirmed repeatedly. NLD young people had experienced domestic violence more often at home and had a history of property offences, lending support to suggestions of their more generalized criminality. Contrary to expectation, there were no significant differences in terms of victim choice. LD young people did engage in ‘nuisance’ behaviours, e.g. exposure, but they also engaged in a wide range of offence behaviours, e.g. trickery. NLD young people, however, exhibited an even wider range of offence behaviours, e.g. vaginal penetration. Investigative and treatment implications are discussed.*

Keywords *Adolescent; comparative study; learning disabilities*

Young people with harmful sexual behaviour

Current British research suggests that young people who display harmful sexual behaviour (HSB) are not a homogeneous population (Almond, Canter & Salfati, 2006; Dolan, Holloway, Bailey & Kroll, 1996; Manocha & Mezey, 1998; Richardson, Kelly, Graham & Bhate, 1997) and that such behaviour can be seen across all social strata irrespective of class, race, culture, age and ability (NSPCC, 2002). For the purposes of this paper, individuals aged between 10 and 18 years will be referred to as “young people”. With the exception of perpetrators’ gender (Davis & Leitenberg, 1987; Gilby, Wolf & Goldberg, 1989), research has shown that there is no characteristic that is shared by the majority of young people who sexually harm (Almond et al., 2006). There is, therefore, no “typical” young sex offender (Beckett, 1999). The observed heterogeneity suggests that there may be identifiable subgroups of young people who sexually harm, and research suggests that young people who sexually harm who also have learning disabilities (LD) represent one important subgroup requiring further attention (Dolan et al., 1996; Lambrick & Glaser, 2004).

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Learning disabilities would appear to be over-represented among sex offenders (Murphy, Coleman & Haynes, 1983), with an estimated one-third to one-half of all young people who display HSB having a LD or experiencing significant educational difficulties (Almond et al., 2006; Dolan et al., 1996; Hawkes, Jenkins & Vizard, 1997; Vizard, 2000). While offending is generally uncommon among people with LD, sexual offending appears to be disproportionately present, being the most commonly reported offence in many studies (Day, 1994; Thomas & Singh, 1995). Conversely, non-sexual criminal and antisocial behaviour is a recognized background feature for many young people who display HSB (Dolan et al., 1996; Richardson, Graham, Bhate & Kelly, 1995; Ryan, Miyoshi, Metzner, Krugman & Fryer, 1996; Van Ness, 1984), but with the exception of arson (Raesaenen, Hirvenoja, Hakko & Vaesaenen, 1994) this does not seem to be the case for young people with LD who display HSB. Day's (1993) review of studies concerning LD sex offenders, over a 40-year period, identified rates of sexual offending among imprisoned LD individuals as between 12% and 46%. However, only around 6% of adult men with LD are estimated to have problems with severe sexual aggression (Swanson & Garwick, 1994), and a review of probation sex offender programmes in the West Midlands (Allam, Middleton & Browne, 1997) found that only 8% of adult men referred were identified as having a LD. The rates of LD among young people who display HSB are therefore significantly higher than that for adults.

This over-representation of LD in samples of young people with HSB may be due to factors such as imprecise definition, testing problems and the impact of trauma and neglect on young people's development leading them to be placed in the category of "learning disabled" (O'Callaghan, 2001). O'Callaghan (2001) goes on to argue that less able young people are also more likely to have their behaviour identified due to higher levels of scrutiny and observation experienced by young people with LD. Also, certain behaviours that are not viewed as problematic in the general population, e.g. excessive masturbation, may be identified as problematic when carried out in the care settings provided for young people with LD. The absence of private space, limited social networks and poor social skills, some argue, leave a developing adolescent with little direction for non-problematic sexual expression (Lambrick & Glaser, 2004; O'Callaghan, 1999). These problems may also be exacerbated by the young person's caregivers' preconceptions about sexual maturity; they may view the young person in terms of their perceived developmental rather than chronological age, a concept defined as "developmental suspension" (Fairburn, Rowley & Bowen, 1995).

Although there is a lack of research comparing young people who display HSB with LD and those without learning disability (NLD), research that is available reports a number of similarities and differences between these two groups.

Differences between LD and NLD young people who exhibit HSB

In addition to suggestions that LD young people who exhibit HSB have a less eclectic criminal background (although see Fortune & Lambie, 2004 below for an alternative view), comparative research has identified a number of differences between these two populations. For example, research has shown that while LD young people with HSB exhibit the same range of sexually abusive behaviours as NLD young people with HSB (Fortune & Lambie, 2004). Some researchers have found that LD young people are more likely to engage in non-assaultive "nuisance" behaviours such as exhibitionism and public masturbation (Gilby et al., 1989; Stermac & Sheridan, 1993); as a result they may display fewer penetrative behaviours. LD young people with HSB also reportedly use fewer grooming behaviours (Timms &

Goreczny, 2002), more physical force and more verbal threats against their victims (Fortune & Lambie, 2004), leading some researchers to conclude that they demonstrate less sophisticated forms of offending.

Young people with LD who exhibit HSB are also reported as being less discriminate in their choice of victims. They are reported to offend equally against male and female victims (Fortune & Lambie, 2004; Gilby et al., 1989), unlike their NLD counterparts who tend to offend against females. LD young people with HSB also have higher rates of sexual offending against peers than NLD young people with HSB (Gilby et al., 1998) and are reportedly less likely to know their victim than are NLD young people (although Fortune & Lambie, 2004 report no such differences). Ryan and Lane (1991) suggest that their relative indiscriminate in victim age and gender may relate to young people with LD with HSB being more opportunistic in their offending behaviour than are NLD young people with HSB. The nature of their disability may also limit the range and diversity of contact with individuals, narrowing potential victims to those in close or frequent proximity, although the National Organization for the Treatment of Abusers (NOTA) warn about the use of victim characteristics as a method of differentiating young people who display HSB because adolescents in general, irrespective of their intellectual functioning, tend to be more opportunistic in their victim choice rather than in targeting specific victims or groups (NOTA, 2001).

Finally, there is evidence to suggest that there may be differences in the backgrounds of both groups. Young people with LD are unfortunately vulnerable to forms of abuse themselves, and Stermac and Sheridan (1993) report that LD individuals are four times more likely than NLD individuals to have been sexually abused. Other researchers report similar findings (Fortune & Lambie, 2004; Lindsay, Law, Quinn, Smart & Smith, 2001). It is argued that the high rates of abuse found in young people with LD who display HSB may contribute to the more severe levels of behavioural and psychological problems that can be found in this population. For example, Fortune and Lambie (2004) report a complex range of social and behavioural problems for “special needs” adolescents, including increased delinquency in their sample. For an alternative view, however, Gilby et al. (1989) found that LD young people who display HSB exhibited less general delinquent behaviour problems and less family disruption than NLD young people with HSB. Abusive family environments are also reported commonly in the backgrounds of the majority of people who sexually harm (Almond et al., 2006; Alywin, Studer, Reddon & Clelland, 2003; Barbaree, Marshall & McCormick, 1998), therefore background characteristics may not be expected to discriminate LD and NLD young people who exhibit HSB.

Similarities between LD and NLD young people who exhibit HSB

In Timms and Goreczny's (2002) literature review they argue that from a clinical standpoint there are more similarities than differences between LD and NLD young people who display HSB. Becker and Abel (1985) report that both populations suffer from a range of social and psychological impairments, including low self-esteem, social isolation, fear of intimacy and poor social skills. Similarly, Swartz and Masters (1983) found that both populations exhibit complex cognitive and behavioural deficits, various levels of denial, immature social and sexual skills, lack of assertiveness, high criticism, obsessive deviant sexual fantasies, poor empathy and poor impulse control. According to Lambrick and Glaser (2004), these features may indicate a propensity to be detected among both populations rather than a propensity to commit offences. In a study by Gilby et al. (1989), they found that both LD and NLD young people who display HSB have histories of school

problems, social deficits and behavioural problems. Swartz and Masters (1983) also report that both populations exhibit a similar range of offence behaviours and have similar arousal patterns. Further comparisons of perpetrator and abuse characteristics might therefore be expected to reveal little discrimination.

Summary and hypotheses

In summary, the available evidence points towards a profile of young LD sex offenders who have less eclectic criminal backgrounds, who have more often been the victim of sexual abuse themselves, are more indiscriminate in their choice of victim and are less sophisticated in their offending behaviours than are their NLD sex offending counterparts. This portrait, however, is too simplistic and the small number of inconsistent research findings must be brought into mind when formulating testable hypotheses.

Aims of the study

Given that limited British descriptive research exists comparing LD and NLD young people who display HSB, the aim of this study is to investigate the similarities and differences between these two groups in respect of their perpetrator, victim and abuse characteristics. Any reported differences would help to indicate the potential value in considering LD young people who display HSB as a recognizably distinct subgroup within the young people who sexually harm population. This study will also increase our knowledge about LD young people who display HSB which will help to inform the theoretical understanding, management and treatment of these individuals.

Hypotheses

The following one-tailed hypotheses were ascertained from the literature; where there were inconsistent findings in the literature the general consensus was utilized.

Perpetrator characteristics

- NLD will have a more disorganized and disruptive family environment than LD.
- LD will have suffered a greater history of abuse than NLD.
- LD will display greater behavioural and social deficits.
- NLD will display a more eclectic previous offending history.

Victim characteristics

- LD are more likely to offend against male victims than NLD.
- LD are more likely to offend against peer-age victims than NLD.
- LD are more likely to offend against strangers than NLD.

Abuse characteristics

- NLD will display more penetrative behaviours than LD.
- LD will display more “nuisance” behaviours than NLD.
- LD will display greater physical methods of coercion than NLD.

Method

Information was obtained from two specialist agencies that work with children and young people who display HSB. Due to problems with definition and testing only young people who have been diagnosed formally as suffering from a LD were included in the LD sample. Although the authors recognize that some young people with educational difficulties may have failed to be formally diagnosed, efforts were made to exclude any such potential individuals in this sample.

G-Map is an independent provider that offers a range of services for young people who sexually harm, including assessment, individual therapy, group work programmes, family programmes, specialist residential care and training and consultancy. The agency was established in 1988 and is based in Greater Manchester, although it is nationally accessible. The 5A Project has, since 1994, provided a systematic and consistent service for young people in Liverpool with problematic sexual behaviour. Additional funding in 1999 meant that the project could extend its services to young people throughout the Merseyside area. The project currently provides a range of services for young people and their families including assessment and direct work, as well as resources and support for practitioners.

Examination of all the case files from the two agencies identified 51 young people who had been diagnosed as suffering from a LD. These young people were then matched to a comparison group (NLD) on the basis of age and gender. The young people were also matched on the agency from which they were referred to, as the authors felt that there may be different criteria for referring an individual to a particular agency. The sample population for this paper therefore contained 102 young people; 70 of the young people were referred to G-Map and 32 to the 5A Project. Of the 51 LD young people, 21 were diagnosed as having a mild LD, 26 were diagnosed as moderate and four as severe.

The data are derived from extensive and detailed retrospective review of available case files. These included, where available, previous social services, school, psychological, psychiatric, youth offending team and police records. A data collection form collected basic demographic data as well as characteristics relating to the perpetrator’s family environment, history of abuse, behavioural and social deficits and other offending behaviour. In addition, information was collected on the victims of the young person and the abusive incident for which they were referred. In line with a specially agreed arrangement between researcher and agencies in this study, the authors had no contact with young people. An independent observer was used to investigate the inter-rater reliability of the data collection form. A kappa correlation coefficient of 0.76 was generated between two independent observers. Further details of the data collection form can be found in Almond et al., 2006. In order to examine the similarities and differences between the two groups, the frequencies of the variables relating to the perpetrator, the victim and the abusive incident itself were analysed. χ^2 distribution analysis was utilized with an alpha level of 0.05.

Results

Perpetrator characteristics

Demographics. Individuals in each group were matched for age and gender. Each group contained 49 males and two females. The mean age in the LD was 14.78 and the mean age in the NLD group was 14.82. This slight difference was due to the lack of female perpetrators who could be matched with a female learning disabled perpetrator. Therefore, in the case of the two female perpetrators they were matched as closely in age to another perpetrator as possible; however, an exact comparison could not be made. The comparisons that were found, however, did not differ more than one year in age.

Family environments. Table I includes an overview of the characteristics relating to the perpetrators' family environment. As the table indicates, the majority of the comparisons were non-significant. There was, however, a significant difference between the two groups in terms of witnessing domestic violence. A number of the NLD young people, one in four, had witnessed domestic violence. This was significantly higher than the LD young people ($n = 3$, 6%, $\chi^2 = 6.33$, $p = 0.006$). The family environments of the NLD, with the exception of witnessing domestic violence, was not significantly more dysfunctional or disruptive than the family environments of the LD.

History of abuse. Contrary to expectations from the research literature there were no significant differences in previous sexual abuse experienced by LD and NLD young people who display HSB. Approximately equal proportions of each group had been the victim of forms of abuse, therefore this study has not found any differences in history of abuse for LD and NLD young people who sexually harm (see Table I).

Table I. *Perpetrator characteristics.*

	Learning	Disabled	Non-learning	Disabled
Characteristic	n	%	n	%
Family environment				
Care	18	35	11	22
History of removal	12	24	17	33
Domestic violence	3	6	12	24*
Parental alcohol/drug abuse	5	10	6	12
Parental/sibling offending	7	14	5	10
History of abuse				
Victim sexual abuse	13	25	17	33
Victim physical abuse	16	31	17	33
Victim of emotional abuse	6	12	5	10
Neglect	18	35	11	22
Behavioural and social deficits				
Social isolation	11	22	10	20
Low self-esteem	4	8	5	10
Behavioural problems at home	19	37	17	33
Behavioural problems at school	10	20	17	33
Confusion about sexuality	12	24	4	8*
Other offending behaviour				
Previous sexual offence	16	31	13	25
Previous offence against person	4	8	3	6
Previous offence against property	7	14	16	31*
Alcohol/drug abuse	4	8	10	20*

* $p < 0.05$.

Behavioural and social deficits. As Table I shows, the majority of the comparisons were non-significant. The LD sample ($n = 12$, 24%), however, was significantly more likely to be confused about their sexuality than the NLD sample ($n = 4$, 8%, $\chi^2 = 4.74$, $p = 0.029$). Therefore, the LD did not display more behavioural and social deficits than the NLD, with the exception of confusion around their sexuality.

Other offending behaviours. As shown in Table I, the proportion of young people who had committed a previous sex offence that had been investigated by the police was similar for both samples, therefore there were no significant differences between the two groups in terms of previous sexual offences. There was also no significant difference in terms of previous offences against the person. There were, however, significant differences in the perpetrators alcohol/drug abuse ($\chi^2 = 2.98$, $p = 0.042$), with the NLD ($n = 10$, 20%) displaying significantly greater levels than the LD ($n = 4$, 8%). As might be expected from the research literature, there was a significant difference between the samples with regard to previous offences relating to property. The NLD ($n = 16$, 31%) were significantly more likely to have a previous conviction for property offences than the LD sample ($n = 7$, 14%, $\chi^2 = 4.55$, $p = 0.018$).

The NLD, therefore, displayed a more eclectic offending history in terms of committing previous property offences; they also suffered from a greater degree of alcohol and/or drug problems than the LD.

Victim characteristics

Demographics. Contrary to findings from the research literature the demographic profile of victims for both groups were remarkably similar. Information regarding victim characteristics was missing from some of the case files. This was due either to error in the case files or the fact that there was no specific victim, i.e. exposure to a group of people. Based on the available information, the mean age for the victims was 9.8 years for the LD young people and 11 for the NLD young people (not significant). There were no significant differences between these two groups in terms of victim age, gender or relationship (see Table II).

Abuse characteristics

For a number of the perpetrators the abuse was not an isolated incident, in that it occurred with a victim on more than one occasion. There was no significant difference between the two groups on this characteristic. However, as shown in Table III, the NLD were significantly

Table II. *Victim characteristics.*

	Learning	Disabled	Non-learning	Disabled
Characteristic	n	%	n	%
Victim age				
Child	33	65	33	65
Peer/adult	16	31	15	29
Victim gender				
Male	15	29	14	27
Female	35	69	36	71
Relationship				
Relative	16	31	16	31
Acquaintance	27	53	24	47
Stranger	5	10	7	14

Table III. Abuse characteristics.

	Learning	Disabled	Non-learning	Disabled
Characteristic	n	%	n	%
More than one incident	13	25	18	35
Longer than six months	4	8	12	24*
Nature of abusive behaviour				
Exhibitionism	13	25	6	12*
Oral contact with genitals	4	8	9	18
Victim oral contact perpetrator genitals	1	2	6	12*
Perpetrator oral contact victim genitals	3	6	6	12
Anal penetration	8	16	6	12
Anal penetration with penis	7	14	4	8
Anal penetration with finger	1	2	1	2
Vaginal penetration	11	22	21	41*
Vaginal penetration with penis	6	12	9	18
Vaginal penetration with finger	6	12	15	29*
Perpetrator touches victim genitals	24	47	23	45
Victim touches perpetrator genitals	8	16	6	12
Touched victim's breasts	9	18	8	16
Perpetrator kiss victim	11	22	7	14
Method of coercion				
Physical coercion	13	25	12	24
Single act of violence	2	4	2	4
Multiple acts of violence	3	6	2	4
Violence beyond level necessary	0	0	4	8*
Weapon	2	4	5	10
Another perpetrator involved	4	8	5	10
Verbal threat	9	18	8	16
Emotional threat	2	4	2	4
Inducement	5	10	4	8
Bribes	2	4	2	4
Trickery	6	12	2	4

*p < 0.05.

more likely to victimize an individual repeatedly over a long period of time (over six months) (n = 13, 25%) as opposed to the LD sample (n = 4, 8%), $\chi^2 = 4.74$, p = 0.029.

Nature of the abusive behaviour. In terms of the actual behaviour these young people were displaying, Table III shows that there were a number of differences between the two groups. Coercing the victim to make oral contact with the perpetrator was significantly higher in cases of NLD young people (n = 6, 12%) than LD young people (n = 1, 2%, $\chi^2 = 3.84$, p = 0.05).

In terms of vaginal penetration there were, as Table III shows, further differences between the two groups. The case files indicated that there were nearly twice as many reports of vaginal penetration by the NLD young people (n = 21, 41%) than the LD young people (n = 11, 22%). This result was statistically significant ($\chi^2 = 4.55$, p = 0.033). There were also significant differences between the two samples with regard to vaginal penetration with the finger; the NLD sample reported more than twice as many incidents involving vaginal penetration with the finger (n = 15, 29%) than the LD sample (n = 6, 12%; $\chi^2 = 4.86$, p = 0.028). Conversely, as Table III shows, the proportion of anal penetration was similar in both samples. There was a significant difference between the two groups in terms of "nuisance" behaviours; the LD sample reported twice as many incidents of exhibitionism (n = 13, 25%) than NLD (n = 6, 12%). Comparisons of other abusive behaviours revealed no further

statistical differences (see Table III). Therefore, there was some tentative evidence that the NLD display greater penetrative behaviours than the LD, although this was not found to be the case for anal penetration. There was also some evidence to suggest that the LD displayed greater nuisance behaviours than the NLD.

Methods of coercion. As shown in Table III the rate of physical, verbal and psychological methods of coercion within the two samples was very similar. The only significant difference between the groups was with regard to the perpetrator displaying violence beyond that necessary to control the victim, e.g. burning or cutting the victim. Contrary to suggestions from elsewhere in the research literature, the NLD sample reported higher levels of this type of violence ($n=4$, 8%) than the LD sample did ($n=0$; $\chi^2=4.16$, $p=0.041$). The NLD and LD, therefore, display very similar methods of coercion.

Summary and discussion

Similarities between LD and NLD young people who exhibit HSB

Throughout the comparative analysis similarities between the two groups were confirmed repeatedly. Each group demonstrated similar family environments, including parent and sibling characteristics and previous experiences of physical, emotional and sexual abuse. As has been indicated elsewhere in the research literature, evidence from this study also suggests that both groups had similar levels of behavioural and social deficits, including social isolation and low self-esteem. A similar proportion of individuals from each group had also committed sexual offences or an offence against a person previously.

Contrary to expectations from the literature (e.g. Gilby et al., 1989; Ryan & Lane, 1991) there were no discernible differences between the two groups in terms of victim choice; the demographic profile of victims for each group being similar with regard to victim age, gender and relationship with the perpetrator. Therefore, there was no evidence to support assertions made elsewhere in the literature that LD sex offenders are more indiscriminate in their choice of victims. The results of this analysis did indicate a greater confusion about sexuality among LD young people than NLD young people. Further research with larger sample sizes would need to consider this more closely before any firm conclusions could be reached.

Many of the behaviours LD young people exhibited during the abusive incident were also found to be very similar to those exhibited by NLD young people. The two groups displayed similar levels of anal penetration, touching the genitals, touching the breasts and kissing the victim. They also used similar rates of coercion—physical, verbal and psychological methods such as inducement and bribes—indicating a similar degree of sophistication in their offence behaviour.

Differences between LD and NLD young people who exhibit HSB

The two samples were significantly different from each other in very few of the characteristics under study. It was found that the NLD young people had more probably witnessed domestic violence in the home. Also, they more often had a previous conviction from a property offence. This provides some support for suggestions evidenced elsewhere in the literature that British adolescents who display HSB have a higher incidence of property offences and therefore perhaps a more eclectic criminal background (e.g. Almond et al., 2006; Dolan et al., 1996; Gilby et al., 1989; Richardson et al., 1995).

There were some differences in the behaviours displayed during the abusive incident. LD young people were more likely to commit exhibitionism. However, NLD young people were

more likely to coerce the victim to make oral contact with their genitals, penetrate the victim's vagina and penetrate the victim's vagina with a finger. Contrary to findings elsewhere in the literature (e.g. Fortune & Lambie, 2004), NLD young people rather than LD in this sample were more likely to use violence beyond that necessary to control the victim than were LD young people. Therefore, although LD young people demonstrated a wide range of offending behaviour, NLD young people appear to demonstrate an even wider range of offence behaviours. Episodes of abuse from among NLD young people were also found to last longer (more than six months) than were those from among LD young people. However, this may be due to the higher levels of scrutiny and observation experienced by young people with LD (O'Callaghan, 2001). Lambrick and Glaser (2004), for example, are quick to highlight that there are examples of LD sex offenders who have offending careers spanning several decades.

Future research, incorporating different methodologies and larger sample sizes, could indicate further important differences between LD and NLD groups. The sample size employed here has allowed only for the emergence of general trends. Also, case files are not gathered for the purposes of scientific research and the consistency with which information is recorded and the attention to detail will not be of the standard that is often taken for granted in a research environment (Canter & Alison, 2003). There may also be some minimization of sexual information in caregivers' attempts to protect an offending young person. These problems are compounded further when analysis is undertaken retrospectively. For example, findings here, such as confusion over sexuality among LD young people, may be sensitive to reporting errors or inconsistent reporting across agencies and between agency workers. Further work with larger sample sizes, incorporating interviews with perpetrators, their families and other relevant agencies could serve to validate the results of this analysis.

Conclusion

The results of the study show there are more similarities than differences between samples of LD and NLD young people who exhibit HSB. The similarities included the majority of the perpetrator characteristics, all the victim characteristics and a large proportion of the offence characteristics. There were, however, some important differences between the two groups and the value of categorizing LD young people as a specific subgroup must now be considered more closely.

A potential value of establishing recognizable subgroups is in assisting investigating officers to understand more fully the interplay between intellectual and sexual maturity and how this could relate to situational opportunities for offending, including offence behaviour and victim choice. The findings from this study suggest that the abusive behaviours demonstrated by LD and NLD young people often share similar features, with NLD youths arguably demonstrating a wider range of sexual behaviours, including vaginal penetration. Based on this research, therefore, it would seem that there is limited scope in differentiating sexual behaviour of offenders based upon underlying differences in intellectual impairment. Similarly, there were few differences in terms of victim choice. These findings challenge suggestions elsewhere in the literature that young LD sex offenders display less sophisticated forms of offending against a more homogeneous victim group. Further work, with larger sample sizes, is now required to help shed further light on these issues.

Another value exists in ensuring that youths who sexually harm are receiving the most appropriate intervention, treatment and management. According to O'Connor (1997), LD is often an exclusion criteria used by many treatment programmes that might otherwise serve the LD population well. Conversely, Barron, Hassiotis and Banes (2004) report that there is

little evidence to demonstrate the efficacy of NLD interventions for the LD population. The limited number of specialized treatment programmes that do exist focus on simplifying concepts and the use of visual imagery that is so essential for individuals with increasing levels of intellectual impairment. Furthermore, it is reported more frequently in the research literature that rates of sexual recidivism are higher for LD offenders and that LD sex offenders are also more likely to re-offend within a shorter period of time (see Craig and Hutchinson, 2005 for a review). Accordingly, the need for adapted and specialized treatment programmes for LD sex offenders may perhaps never have been greater.

The findings from the present research suggest that there are many similarities in both the backgrounds and levels of social and behavioural impairments between LD and NLD groups. There are also some similarities in their offending behaviour. The treatment and management approaches to both groups would therefore benefit from sharing features in common and some individuals with mild LD could be best served under mainstream programmes. Set against this, the finding that LD young people rarely engage in wider criminal acts suggests that there are important differences between the two groups that require different broad-based management approaches. Further work looking at any within-group differences for LD sex offenders would clearly be beneficial, especially as it relates to level of disability (mild, moderate, severe). This could be used to inform assessment procedures for mainstream programmes and help redirect offenders that would benefit most from specialized programmes. For example, the next phase of research by the present authors looks at whether LD offenders (representing a wide range of intellectual functioning) demonstrate the same modes of interaction with their victims, as has been seen with adult and adolescent sex offenders (Almond & Canter, 2007). Through more detailed multivariate analysis of these potential within-group differences in addition to further between-group comparisons it may be possible to understand more fully the delicate interplay between intellectual and sexual maturation and behaviour, and the factors that give rise to sexual offending among young people.

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