Child on Child Sexual Abuse Needs Assessment

A Literature Review
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INTRODUCTION

Sexual assaults committed by youth are of increasing concern nationwide. Fourteen represents the most common age of individuals engaging in illegal sexual behavior against children under the age of 12. Nearly half of all under-12 child sex crimes involve juvenile-on-juvenile cases (Chaffin, 2008). The average age of victims of these offenses is 10 years (Finkelhor, Ormrod, & Chaffin, 2009; Barbaree, Hudson, & Seto, 1993; Fehrenbach, Smith, Monastersky, & Deishner, 1986). “Children are the most criminally victimized segment of the population, and a substantial number face multiple, serious ‘poly-victimizations’” (Oxford University Press, 2009).

Understanding the children involved in incidents of child-on-child sexual abuse is critical to effective prevention and intervention efforts. However, the causal pathways associated with perpetration and victimization are complex. Some studies have suggested that a pattern of juvenile sexual offending at an early age may serve as a precursor to later victimization and/or offending (Abel et al., 1987; Hunter and Figueredo, 2000; Knight and Prentky, 1993). Others have found that prior peer sexual victimization did not increase the likelihood for later sexual abuse (Maker, Kemmelmeier and Peterson, 2001). A recent examination of a historical official data set found no increased likelihood for adult sexual offending among a cohort of juvenile sex offenders (Zimring et al., 2009). The seeming inconsistency in findings is due to a number of factors.

First, there is no standard definition for child peer sexual abuse or what can be referred to as child-on-child sexual abuse, child molestation, peer/adult sexual abuse or adolescent peer abuse. Often studies will use definitions that are similar; however, variation between studies and a lack of methodological rigor can inhibit reliable generalizations. Second, while there are some commonalities in the literature concerning offender and victim characteristics and risk factors, earlier studies often relied upon non-probability samples with limited sample sizes. Third, the absolute prevalence and frequency of these incidents are unknown. Disclosure rates or the rate of reporting juvenile sex abuse is unreliable because this type of abuse may be underreported especially in certain contexts. For example, girls are more likely than boys to report abuse, and incidents are more likely to be reported to peers rather than authorities (Priebe and Svedin, 2008).

The lack of knowledge and public education regarding normal childhood sexual behavior also inhibits the
distinction between “normal sex play” and unwanted sexual abuse in the general public. This is problematic because recent increases in juvenile sex abuse statistics in part reflect a growth in the reporting of less serious sex offenses, rather than an actual increase in the frequency of childhood sexual behaviors (Finkelhor, 2008).

These complex factors can inhibit child welfare efforts to provide services and mitigate current or future incidents of child-on-child sexual abuse, such that efforts are limited to treating diagnosed risk factors as opposed to underlying causes. Careful review of recent research, however, sheds greater light on the characteristics and risk factors associated with child-on-child sexual abuse perpetration and victimization.

The current review is intended to provide an empirical review of the research literature on child-on-child sexual abuse. Such abuse can encompass various age-ranges (early childhood, preteen, and teenage years) and legal/official categorizations (juvenile sex offender, child sexual behavior, dependent child, etc.). While teens engaging in child-on-child sexual behaviors and juvenile sex offenders are generally discussed here, the emphasis is on sexual abuse and sexual behavior problems among children. This group represents the primary child-on-child sexual abuse service population of the Florida Department of Children and Families. The review that follows presents research on child-on-child sexual abuse characteristics and risk factors for victims and children who engage in these behaviors, identification and assessment strategies, treatment approaches and outcomes, and policy recommendations for service provision.

**CHILD-ON-CHILD SEXUAL ABUSE CHARACTERISTICS AND RISK FACTORS**

Child-on-child sexual abuse involves children with sexual behavior problems and child victims. Children who engage in this type of abuse, as well as their victims, are diverse and not easily classified into typologies. Child-on-child sexual abuse may involve children of similar or divergent ages; may involve aggression, coercion or force; may involve harm or potential for harm; may occur frequently or infrequently; and may include minor or advanced sexual behaviors. As such, standard definitions of child-on-child sexual abuse are difficult to delineate and are variously used throughout the research literature.
resulting in differences in methodology and findings.

Depending upon local, state, and federal laws, children involved in this form of abuse may be considered a child with sexual behavior problems in need of child welfare services, may be legally defined as juvenile sex offenders or molesters, and/or may be permanently placed on a sex offender registry for involvement in such abuse.

Legal codifications based on age, as well as the nature of the sexual abuse, vary across jurisdictions and empirical studies. Most commonly, child molesters have been defined in the research as children who are more than five years older than their victim and who engage in any unwanted sexual acts with the victim (Browne and Finkelhor, 1986). Peer abusers are generally categorized as adolescent who sexually assault other peers who are within five years of their own age. In either of these types of cases, the child engaging in the sexual abuse may be legally processed, depending on jurisdictional laws and practices, by the juvenile or adult criminal justice system as a sex offender. Likewise, the child may also receive services within the child welfare system. The latter setting and child-on-child sexual abuse are the focus of this review.

**Characteristics and Risk Factors of Children with Sexual Behavior Problems**

Children with sexual behavior problems (SBP) have been defined by Chaffin and his colleagues (2008) for the Association for the Treatment of Sexual Abusers (ATSA) as, “children ages 12 and younger who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others” (p.200).

Childhood sexual behavior problems may involve behaviors that are self-focused or may involve other children. They may be relatively frequent or infrequent, may involve mutuality or coercion, or may occur during times of stress, anger, or frustration. Concern arises when sexual behavior problems involve substantial age or developmental inequalities between the perpetrator and the victim; more advanced sexual behaviors; use of aggression, force or coercion; and harm or potential for harm (Chaffin et al., 2008).

Children with significant sexual behavior problems should be distinguished from those who engage in sexual behaviors considered normal and age-appropriate. Several researchers have described differences between normal sexual development and inappropriate sexual behaviors (Beech, Craig and Browne, 2009; Phil, 2009; Chaffin et al., 2008).

**Sexual Development and Exploration**

Specifically, Rich (2009) states that sexual development and sex play are a normal and healthy process of progression into adulthood. Early in life, it is common for babies and toddlers to touch their own genitals. From ages 5 to 7 some
sexual play may begin and this will last until puberty (8 or 9 years of age). Around age 10 to 12, youth begin to focus on social relationships within the family and school and they begin to experience sexual feelings. By adolescents, their body parts and sex organs are developing.

While some youth may engage in sexualized behaviors throughout their childhood, these behaviors become a concern when they are extensive, when they are unwanted by other children, when they suggest a preoccupation with non-consensual acts, and when they cannot stop their behavior once asked by a parent or guardian. There are likewise sexually reactive children, or those who have been exposed to inappropriate sexual activities and act out by virtue of their exposure.

Johnson (1999) lists signs of concern in children up to the age of 12. These include:

- Children should not be preoccupied with sexual play, and should not engage in many other forms of sexual play;
- Children should not engage in sexual play with much younger or much older children;
- Children should not have precocious knowledge of sex beyond their age;
- Children’s sexual behaviors and interests should be similar to those of other same-age children;
- Children should not be "driven" to engage in sexual activities, and they should be able to stop when told to do so by an adult;
- Children’s sexual play should not lead to complaints from or have a negative effect on other children, and should not cause physical or emotional discomfort to themselves or others;
- Children should not sexualize relationships, or see others as objects for sexual interactions;
- Children aged 4 and older should understand the rights and boundaries of other children in sexual play;
- Children should not experience fear, shame, or guilt in their sexual play;
- Children should not engage in adult-type sexual activities with other children;
- Children should not direct sexual behaviors toward older adolescents or adults;
- Children should not engage in sexual activities with animals;
- Children should not use sex to hurt others; and,
- Children should not use bribery, threats, or force to engage other children in sexual play.
Typologies

A number of typologies have been proposed for classifying youth who engage in risky sexual behavior (Berliner et al., 1986; Bonner et al., 1998; Graves et al., 1996; Hunter et al., 2003; Knight and Prentky, 1993; O’Brien and Bera, 1986; Weinrott, 1998; Worling, 2001). For example, Berliner and colleagues (1986) created a classification system of sexual problematic behaviors in children which outlines three types of sexually inappropriate behavior: precocious, inappropriate, and coercive sexual behaviors. Knight and Prentky (1993) included six categories of offenders including: rapists, child molesters, sexually reactive, fondlers, paraphilic offenders and unclassifiable. Paraphilic offenders are those who are sexually aroused by objects or situations that are not part of normative stimulation, and which can lead to distress or serious problems for the offender or those associated with the individual (APA DSM-IV, 1994). Most recently, Hunter and colleagues (2003) identified three profiles in order to classify offenders over the life course: lifestyle persistent, adolescent onset/nonparaphilic, and early adolescent onset or paraphilic.

One problem noted with the use of these typologies is that they are often too complex and they are not mutually exclusive. In other words, categories or classifications may overlap extensively. For example, in Knight and Prentky’s typology a fondler could also be considered sexually reactive. Studies have documented clusters of behaviors with distinct overlap, suggesting the lack of any clearly defined taxonomic subgroups (Bonner et al., 1999; Pithers et al., 1998; Chaffin et al., 2008).

As Chaffin et al. (2008) note, qualitatively different sexual behavior subtypes among children are not founded in the empirical research literature. Rather, children are found to have ranges of SBP in terms of severity and intensity. More intense ranges often include comorbid mental health, social and family problems (Hall, Mathews, Pearce, Sarlo-McGarvey, & Gavin, 1996; Chaffin et al., 2008).

Contributing Factors

Understanding and addressing the needs of children with sexual behavior problems requires ecological assessments of family, school, economic, social, and environmental contributing factors (Friedrick, Davies, Feher, & Wright, 2003; Friedrich et al., 2001). Research has consistently found that children who engage in sexual assaults of other children have themselves often been the victim of sexual abuse (Becker and Murphy, 1998). While past sexual victimization can increase the likelihood of sexually aggressive behavior, most children who are sexually abused do not engage in sexual offending. Furthermore, many children with sexual behavior problems present with no known history of sexual abuse. There are various pathways to childhood sexual behavior problems. Chaffin and his colleagues (2008) emphasize that “childhood SBP are sufficient to raise the question of sexual abuse but should not be considered sufficient, by themselves, to
conclude that sexual abuse has occurred” (p.205).

Often however, caregivers, may erroneously conclude that child sexual behavior problems are caused by prior abuse and the absence of documented evidence of such abuse is itself indicative of serious problems. In such cases, they may continue to pursue such evidence to the detriment of the child. Sexual behavior, as is the case with any human behavior, arises from a number of complex and often intertwined causes (Chaffin et al., 2008). When evidence of prior sexual victimization is not definitive, the Association for the Treatment of Sexual Abusers Task Force recommends:

- Educating children about sexual abuse;
- Identifying who children might tell if they were abused;
- Identifying significant adults who can support this message; and
- Building support systems around the child (Chaffin et al., 2008).

Patterns have also emerged within the literature concerning the various types of juvenile sex offenders in relation to their victims. Juvenile child molesters tend to be shy, socially awkward and have difficulties with peer relationships, while child peer sexual abuse offenders tend to be controlling, aggressive and have difficulty managing their anger (Richardson et al., 1988).

Additional factors may also distinguish children engaging in child-on-child sexual abuse including: age at time of first perpetration, number of victims, age of victim, gender of victim, relationship to victim, number of perpetrators, gender of perpetrators, fantasy prior to perpetration,
and masturbation prior to perpetration (Hunter et al., 1993; Hunter, Hazelwood and Sledinger, 2000; Maker, Kemmelmeier and Peterson, 2001; Sperry and Gilbert, 2005; Worling, 1995).

Several personality traits have been identified as risk factors of child peer sex offending including: unpopular among peers, hostile, aggressive, low self esteem, adversarial sexual beliefs, rape-myth acceptance, and prior physical abuse as a child (Hunter et al., 1993; Hunter, Hazelwood and Sledinger, 2000; Maker, Kemmelmeier and Peterson, 2001; Sperry and Gilbert, 2005; Worling, 1995).

Youth who engage in sexually assaultive behaviors have frequently been diagnosed with other co-morbid behaviors such as:

- Defiant Disorder,
- Conduct Disorder,
- Substance abuse,
- Attention Deficit Hyperactivity Disorder (ADHD),
- Developmental disabilities,
- Learning disorders,
- Autism and Asperger’s Syndrome,
- Bipolar disorders,
- Reactive Attachment Disorder,
- Posttraumatic Stress Disorder, and
- Biological deficits (see Schwartz, 2009, pp. 5-12 for a brief synopsis).

While children engaging in child-on-child sexual offending may be diagnosed with other non-sexual behavioral problems, it is important that risk assessments be comprehensive in order to provide services for youth that treat the cause of the behavior rather than merely the symptoms. For example, youth who act out may be diagnosed with Reactive Attachment Disorder because they have been a victim of sexual abuse. Establishing the chronological order of factors potentially contributing to childhood sexual behavior problems is an important component to effectively addressing child-on-child sexual abuse. These issues are discussed further within the assessment section of this review.

The co-morbid behaviors noted above are important to understanding factors that may be simultaneously involved in cases of child-on-child sexual abuse. Schwartz and colleagues (2006) recently outlined a distinct set of risk factors that
may be helpful in identifying sexually aggressive youth. In their comprehensive analysis of 813 sexually abusive juveniles in Massachusetts, they found that common risks among juvenile sex offenders included a history of pregnancy and birth complications (25%), alcohol abuse during pregnancy (15%), drug abuse during pregnancy (20%), head trauma (14%), and an increased likelihood of attending special education classes. They also found that offenders were often characterized by instability within the home including: early age of placement in foster care (average age, 7 years), early placement in a residential facility (average number of years, 11), numerous home placements (5 times on average), and a large number of total changes in the living situation (10 times on average).

Like other studies, the research team documented that offenders themselves were likely to have suffered from prior abuse. Such abuse included neglect (93%), psychological abuse (49%), and sexual abuse (81% females, 63% males). Female offenders were more likely to be the victim of neglect, have an earlier age at onset, and to have witnessed sexual deviance (42% females, 31% males) and domestic violence (84% females, 73% males), in comparison to their male counterparts. Girls were also more likely than boys to be abused for a longer duration and have a greater number of perpetrators (Schwartz et. al, 2006: 70-71).

Risk to Re-Offend

It has been repeatedly documented through robust empirical evidence that children with sexual behavior problems and juvenile sex offenders have relatively low future sex offending rates (2% to 15%) (Chaffin, 2008; Chaffin et al., 2008; Carpentier, Silovsky, & Chaffin, 2006). While these findings may seem counterintuitive juxtaposed against adult sex offenders who report childhood onset of their sexual aggression, recent longitudinal studies suggest that childhood sexual behavioral problems and even juvenile sex offending does not significantly predispose one to engage in adult sex offenses (Carpentier et al., 2006; Zimring, Jennings, Piquero, & Hays, 2009).

Although relapse and recidivism among these populations is relatively rare, it is possible to identify risk factors that increase the likelihood for re-offending. Comprehensive meta-analytic studies have yielded a number of risk factors associated with recidivism among juvenile sex offenders. Roberts and colleagues (2002) identified two risk factor domains: sexual deviance and antisocial activity. These domains have also been used in other
meta-analyses (See Hanson and Bussière, 1998; McCann and Lussier, 2008).

McCann and Lussier (2008) conducted a meta-analysis and uncovered forty-eight risk factors associated with sexual deviance, antisocial activity and reoffending in juvenile sex offenders. Their meta-analysis included eighteen studies and a total of 3,189 sex offenders (McCann and Lussier, 2008:369). Risk factors were classified into the following categories: criminal history, index offense characteristics, victim characteristics, psychological/personality characteristics, behavioral factors, and cognitive emotional characteristics.

After excluding studies that were not inclusive of these categories, there were a total of fifteen risk factors derived from the five remaining studies (McCann and Lussier, 2008:369-371). Of those risk factors (15), nine were positively associated with sexual recidivism of juvenile offenders:

- Stranger victim,
- Child or adult victim (as opposed to peer victim),
- Threats/weapon used,
- Prior sexual offenses,
- Male victim,
- Intake age (older offenders), and
- Prior nonsexual offenses (McCann and Lussier, 2008: 374).

When looking at sexual reoffending over the life span, one longitudinal study completed by Zimring and colleagues (2009) offered an analysis based on repeat juvenile offenders through age 26. The researchers utilized data from the Second Philadelphia Birth Cohort, which involved 13,160 boys and 14,000 girls followed from birth through young adulthood (age 26). The study sought to examine sex offenders’ history and involvement in sexual offending over the life course. Zimring et al., identified four major findings from their analysis:

1. Through the first eight years of adulthood, only one in 10 of the male and female juvenile sex offenders had a subsequent sex-related offense.
2. The overwhelming majority (92%) of the males in the cohort who had an adult sex offending record had no prior juvenile sex offense.
3. Males with no prior sex offenses but five or more juvenile police contacts, were twice as likely to commit a sex crime in adulthood, as a juvenile sex offender with less than five total juvenile police contacts.
4. Being a juvenile sex offender did not significantly increase the odds of becoming an adult sex offender, nor did it significantly increase the frequency of juvenile sex offending.

The authors concluded that the growing evidence of a lack of continuity in sexual offending over the life course from adolescence to adulthood, calls into question current sex offender registration and notification laws as they apply to juvenile sex offenders. This is particularly important in light of the significant collateral consequences of sex offender
registries such as labeling, loss of employment, harm to interpersonal relationships, and harassment (Zimring et al., 2009).

In summary, the literature on children who engage in child-on-child sexual abuse and juvenile sex offending suggests that they are subject to a wide range of negative personality traits, problem behaviors and have a history of instability within the family. Evidence to date suggests that there are differences among offender types (child molester versus child peer sexual offenders), as well as gender differences in the characteristics and risk factors of offenders. Recent meta-analysis research has identified important factors positively associated with sexual recidivism of juvenile offenders including: victims who were strangers, children, or males; use of threats and/or weapons, prior history of sexual offending; early age at intake; and a history of prior non-sexual criminal offending.

**Victim Characteristics and Risk Factors**

Victims are overwhelmingly more likely to be females (Hunter and Figueredo, 2000). Victims of juvenile sexual abuse over both the short term and long term often exhibit symptoms of depression, Post-Traumatic Stress Disorder (PTSD), and sexualized acting out behaviors (Browne and Finkelhor, 1986; Paolucci et al., 2001). Other short term effects include low self-esteem, anxiety, guilt, depression, anger and hostility (Bietchman et al, 1991; Browne and Finkelhor, 1986). Additionally, other indicators may include suicidal ideation, running away, truancy, alcohol and drug abuse, and sexual promiscuity (Bietchman et al, 1991). Long term effects of victimization can include self destructive behaviors, feelings of isolation, poor self-esteem, difficulty trusting others and revictimization (Briere and Elliot, 1994; Browne and Finkelhor, 1986; Hunter and Figueredo, 2000).

In those studies that examine the difference between child molester victims and child peer sexual abuse victims, researchers found that child molester victims were more likely to have suffered from severe abuse experiences than those experienced by child peer victims (Sperry and Gilbert, 2005:896). Child molester victims were also more likely to be abused by family members or strangers and the incident was more likely to take place at school or at a relative’s home; whereas child peer sexual abuse victims were more likely to be abused by a boyfriend or girlfriend, a cousin or a friend (Shaw et al., 2000; Sperry and Gilbert, 2005).

Other differences have been noted by Sperry and Gilbert (2005). They reported
that victims of child peer sexual abuse often experienced less intrusive types of abuse (exposing sex organs, touching sexual organs, etc), and had higher levels of psychopathy, psychasthenia and schizophrenia (2005:899).

Carpenter and colleagues (2009) found that victims of child abuse were likely to score higher on Schizoid, Avoidant and Depression scales compared to their peer group. No differences were found however concerning race, sexual abuse history, history of child maltreatment, parent measures, perceptions of negativity and type of sexual abuse. Child peer sexual abuse victims were more likely however to have sexual concerns, sexual distress, and sexual preoccupations (Carpenter, Peed and Eastman, 2009; Shaw et al., 2000; Sperry and Gilbert, 2005). Overall, the primary conclusions from the studies were that victims are most often female and are likely to suffer from extensive mental health problems.

**INTERVENTIONS FOR CHILD-ON-CHILD SEXUAL ABUSE**

This section discusses available assessments as well as treatment interventions for youth involved in child-on-child sexual abuse. Because offenders are often victims of sexual abuse, treatments and services inherently coincide. Given that scientific inquiry into child sexual offending interventions is relatively new, some of the treatments outlined below may have been originally designed for adults and not fully validated for juvenile sex offenders or children with sexual behavior problems. The use and appropriateness of adult sex offender interventions will be discussed in more detail in the sections that follow.

**Identification and Assessment**

Comprehensive assessments of individuals are needed to facilitate treatment and intervention strategies. These include assessments of needs (psychological, social, cognitive and medical), family relationships, risk factors, and risk management possibilities (Righthand and Welch, 2001). It is important that parents and guardians are involved in the assessment and treatment process, to facilitate a more holistic approach and allow for the flexible modification of treatment schedules based on the youth and family’s needs. Families and adolescents should be notified of confidentiality protocols and policies concerning the types of incidents that must be reported to authorities during the assessment process. Open dialogue is the key to uncovering youth/family risks and
needs. The assessment is the cornerstone to effectively understanding family functioning and addressing child-on-child sexual abuse with appropriate services and interventions.

Given the diversity of causal factors, contributing factors, and variations in the severity and intensity of childhood sexual behavior problems, assessment should be ecologically focused and individualized. For most cases, it is not necessary to conduct broad-ranging assessments with extensive testing over numerous sessions as the needed assessment information can be collected from background materials, basic behavioral and psychological histories from parents or caregivers, basic assessment interviews with the child, and the administration of a few simple assessment instruments. In cases involving complicated diagnostic issues, more extensive assessments are warranted (Chaffin et al., 2008)

Chaffin and colleagues (2008) contend that assessment should focus most heavily on current and future contextual factors inside and outside the home. Such factors impact both the appropriateness of certain treatment interventions, as well as their effectiveness. These factors include the quality of the caregiver relationship; adult caregiver monitoring and supervision; presence of positive or negative role models and peers; discipline and limit-setting, and level of disciplinary consistency; child’s response to corrective actions; exposure to and protection from potentially traumatic situations; sexual and/or violent stimulation in child’s past and current environment; resilience factors or strengths that can be developed; and the social ecology of the extended family, neighborhood, school, and other influencing social environments (Chaffin et al., 2008, p. 203).

The authors likewise offer a number of key recommendations for assessing child sexual behavior problems and contributing factors:

- Obtain clear, chronological behavioral description of the sexual behaviors involved.
- Identify when behaviors began.
- Identify when behaviors occur. For example, do they occur during times when the child is stressed, depressed, frightened, or angry? Do they occur when the child is reminded of past sexual abuse or in response to certain environmental triggers, such as sexual stimuli, rough or tumble play? Do they occur only when opportunities present themselves, as opposed to planned events?
- Identify how frequently the behaviors occur.
- Identify whether the behaviors have progressed or changed over time, and if so, how they have progressed and changed.
- Identify whether key events in the child’s life occurred at times when sexual behavior problems manifested.
- Use multiple information sources: parents/caregivers, other children, teachers, and potentially extended family.
- When assessing child-on-child sexual abuse, identify how the behaviors were
initiated, the degree of mutuality, whether the behavior was planned or impulsive, and whether coercion, force or aggression to overcome resistance was involved (p. 204).

Assessment Instruments

An important part of an individualized, ecological approach to evaluating children for sexual behavior problems is the administration of age-appropriate assessment instruments. Psychological testing is useful for estimating the extent and nature of sexual behavior problems in children.

The research on assessment instruments includes studies of the validity and reliability of instruments in identifying childhood SBP and appropriate treatment, as well as in predicting subsequent relapse or recidivism. Saunders and colleagues (2004:28-34) set forth four primary domains which require assessment: 1) intellectual and neurological, 2) personality functioning and psychopathology, 3) behavioral deviance, and 4) sexual deviance. Risk assessment accuracy in predicting treatment and recidivism is critical to effectively addressing the needs of children who engage in sexual offending against other children. A number of studies have evaluated the accuracy of assessment measures. Those assessment instruments that have been evaluated are briefly here.

The Child Sexual Behavior Inventory (CSBI) (Friedrich, Beilke and Purcell, 1989; Friedrich, 1997)) is a 38-item instrument completed by a parent or caregiver to determine the presence and intensity of a range of sexual behaviors in children ages 2 to 12. The instrument measures the frequency of common and atypical behaviors, self-focused and other focused behaviors, sexual knowledge, and level of sexual interest. Recent items added to the instrument focus on whether the child’s sexual offending is planned and whether it involves aggression. Age and gender norms have been identified and allow the assessor to discriminate between developmentally normal and atypical sexual behavior. In addition to being used to determine the presence of SBP, the CSBI is also useful for monitoring progress and tracking treatment progress.

The Child Sexual Behavior Checklist (CSBCL-2nd Revision) (Johnson & Friend, 1995) is appropriate for identifying SBP in children 12 years of age and younger. It can be completed by anyone who knows the child well, such as a parent/guardian or adult caregiver. The CSBCL examines 150 behaviors related to sexual behaviors and sexuality in children. It also assesses environmental factors that can increase problematic childhood SBP, asks details about such behaviors with other children, and lists characteristics associated with children’s sexual behaviors (Chaffin et al., 2008; Johnon & Friend, 1995).

The Weekly Behavior Report (WBR) (Cohen & Mannarino, 1997b) is a relatively short instrument appropriate for use with young children and designed to track weekly changes in general and sexual behavior in children. The
instrument is therefore useful for identification and for monitoring progress over time (Chaffin et al., 2008).

Parks & Bard (2006) conducted an evaluation of risk assessments to examine differences in recidivism risk factors and traits for three groups of male adolescent sexual offenders (N = 156): offenders who sexually assaulted children, offenders who sexually assaulted peers or adults, and mixed type offenders. The analysis utilized these typologies to test recidivism among sexual and nonsexual crimes. Data indicated that approximately 6% of the sample reoffended sexually and roughly 30% committed subsequent non-sexual offenses.

The researchers also examined risk assessment outcomes. Youth were assessed using the Juvenile Sex Offender Assessment Protocol-II (JSOAP-II) and the Psychopathy Checklist: Youth Version (PCL:YV). They found that mixed type offenders produced higher risk scores than those who offended against children or adult/peers. Additionally, they found that the Impulsive/Antisocial Behavior scale of the JSOAP-II and the Interpersonal and Antisocial factors of the PCL:YV were significant predictors of sexual recidivism. The Behavioral and Antisocial factors of the PCL:YV were found to be significant predictors of nonsexual recidivism as well (Parks & Bard, 2006). Others have found that the JSOAP-II and the PCL:YV assessments are not predictive of adolescent violent recidivism for sex offenders (Viljoen et al., 2008; 2009).

Viljoen and colleagues (2008) included an examination of three different adolescent risk assessments: the Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (J-SORRAT-II), the Structured Assessment of Violence Risk in Youth (SAVRY) and the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II). These assessments were used to predict violent behavior in 169 male youth who were admitted to a residential sex offender program. While none of these instruments predicted sexual violence, the SAVRY and J-SOAP-II predicted non-sexual violence. Additionally, the J-SOAP-II and the SAVRY were less effective in predicting reoffending in youth ages 15 and younger (Viljoen et al., 2008).

After the 2008 investigation, Viljoen and colleagues (2009) examined four other juvenile sex offender assessments including: the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR), the Youth Level of Service/Case Management Inventory (YLS/CMI), the Psychopathy Checklist: Youth Version (PCL:YV), and the Static-99 to predict reoffending in a sample of 193 adolescents. Youth were followed for approximately 7 years after they were released from a residential sex.
offender treatment program. None of the instruments significantly predicted reoffending; however, the ERASOR nearly reached significance. Both the YLS/CMI and the PCL:YV predicted nonsexual violence, any violence, and any offending; however, the YLS/CMI demonstrated incremental validity compared to the PCL: YV. Additionally, the Static-99 did not predict sexual or nonsexual reoffending, despite empirical support for adult offenders.

Other assessments mentioned in the research literature include:
- Abel Assessment for Sexual Interest
- Minnesota Sex Offender Screening Tool
- Multiphasic Sex Inventory
- Rosenberg Sexual Deviance Deception Assessment
- Sexual Interest and Deviancy Assessment
- Sexual Violence Risk-20 (SVR-20)
- The Sex Offense and Development Assessment.

For additional detail on these cited assessments, see Saunders (2004: 24-30).

The assessment is the foundation for the treatment process. Without accurate, inclusive, and refined assessments followed by reasonable treatment planning, interventions are likely to be misguided and ineffective (Saunders, 2004:30). Care should be taken in conducting assessments in a supportive environment, free from pressure, accusatory language, or biased, suggestive, or leading questions (Chaffin et al., 2008).

**Treatment Interventions**

Research on the effectiveness of treatment interventions for juvenile sex offenders and children with sexual behavior problems has demonstrated positive outcomes for treatment approaches based upon cognitive-behavioral therapy (CBT). While sexual reoffense rates are relatively low for children with SBP and juvenile sex offenders, studies have documented program success in reducing recidivism among this population. Other research has indicated that program effectiveness is dependent in part on the type of intervention and type of sexual behavior problems. What has been noted in the research is that juvenile sex offenders are more likely than adults to respond positively to treatment and that they are also less likely to recidivate than adults (Association for the Treatment of Sexual Abusers, 2000; Worling and Curwin, 2000).

Juvenile sex offenders may come from any socio-demographic background and may present with a variety of different risk factors. It is therefore ill advised to ignore these differences when implementing treatment services. Recognizing that even within gender and race/ethnicity classifications, youths are not a homogeneous group, is critical to effectively addressing the unique criminogenic needs and risks of children with sexual behavior problems. Indeed, as with any interventions intended to curb
deviant behavior, treatment effectiveness is dependent on the client’s responsivity to treatment (Andrews and Gendreau, 1992).

The last decade has ushered in a new focus in child welfare and delinquency systems aimed at implementing evidence-based, or research-informed, practices. Meta-analytic techniques have allowed researchers to more effectively cull the literature and identify interventions which have been proven through rigorous empirical evaluation to reduce subsequent offending. One of the most significant findings from these studies is the efficacy of cognitive-behavioral interventions (Lipsey, 2009; Glick, 2009). These practices address offenders’ cognitive functioning, behavioral motivations, cognitive skills and cognitive restructuring. Interventions are based on the premise that “it is your thoughts, feelings, beliefs and attitudes that control your behavior” (Glick, 2009: xiii). Correspondingly, treatment is designed to examine offenders’ attitudes and values, and use cognitive restructuring and skills development to effect behavioral change (Glick, 2009).

A number of randomized trials have been conducting evaluating the efficacy of treatment interventions among children with sexual behavior problems. Bonner, Walker, & Berliner (1999) randomly assigned children with SBP to either a 12-session psychoeducational, cognitive behavioral group treatment program (CBT) or 12-session play therapy group (involved teaching children simple sexual behavior and boundary rules, involving caregivers in monitoring and supervision activities, and teaching basic impulse control skills). The researchers documented short-term reductions in sexual and nonsexual behavior problems for both randomized cohorts (Bonner et al., 1999).

Long-term follow-up of sexual offense arrests and child welfare sexual abuse perpetration reports ten years after treatment produced outcomes significantly in favor of the CBT intervention (Carpentier, Silovsky, & Chaffin, 2006). Children randomized to CBT had significantly lower rates of sex offense arrests or sex abuse perpetration reports (2%) than children receiving play therapy (10%). Notably, the children receiving CBT were also compared to a clinical group of children diagnosed primarily with ADHD or behavior problems, and who had no known history of SBP. The children with sexual behavior problems who received CBT interventions had roughly the same rate of future sex offenses (2%) as the clinical comparison group (3%) (Carpentier et al.,
These results have led Chaffin and colleagues (2008) to conclude that, “risk for future sexual offenses can be reduced to baseline levels with appropriate shortterm treatment” (p.207).

Pithers and Gray (1993) and Pithers, Gray, Busconi, & Houchens (1998) randomly assigned 115 children with SBP between the ages 6 and 12, and their families, to 32-sessions of either expressive therapy (education about sexual behavior rules, boundaries, emotional management, understanding the effects of sexual abuse, and teaching problem solving and social skills) or a relapse prevention-based program (focused on identifying relapse factors and building a prevention team. Both interventions were based on CBT models. The studies documented improvement in both groups and found that relapse prevention treatment was more effective in cases of serious traumatic stress symptoms (Pithers et al., 1998; Chaffin et al., 2008).

Others have compared CBT interventions for children with sexual behavior problems to nonspecific supportive therapy groups and found that the former was more effective in reducing SBP in children (Cohen and Mannarino, 1996, 1997a). A recent examination included controls for waitlist periods prior to treatment intervention and notably found that the sexual behavior problems tend to improve with time, and that rates of improvement increased when shortterm psychoeducational CBT was introduced (Silovsky, Niec, Bard, & Hecht, 2007).

As discussed earlier, a common risk factor among juvenile sex offenders is a history of prior sexual abuse. Given that offenders have often been the victim of sexual abuse, many treatments work from a foundation of addressing both deviant behavior, as well as victimization and trauma.

Saunders and colleagues (2004) completed one of the most comprehensive analyses in regards to the various interventions available for offenders who have experienced prior physical and/or sexual abuse.

They highlight two specific interventions which address offender behaviors: adolescent sex offender treatment and adult child molester treatment. Both treatments use cognitive behavioral and adjunctive therapies to help offenders develop motivation to change. In addition, replacement therapy is used to help change negative or risky thought patterns and promote prosocial behaviors (Saunders et al., 2004:93-98). Their analyses documented the
importance of treatment that incorporates a multifaceted approach to behavior change, particularly given that most studies report higher rates of non-sexual rather than sexual recidivism. Some common practices among clinical practices include: involving families in the treatment, peer group therapy and other cognitive behavioral approaches such as Multi-Systemic Therapy (MST) (Burton et al., 1996, National Task Force, 1993; Swenson et al., 1998; Letourneau, 2009).

Saunders and colleagues (2004) rated each treatment invention by using the following codes:

- 1 = Well-supported and efficacious treatment
- 2 = Supported and probably efficacious treatment
- 3 = Supported and acceptable treatment
- 4 = Promising and acceptable treatment
- 5 = Innovative or novel treatment
- 6 = Concerning treatment program

Table 1 presented below outlines the results of their analysis of 24 different program types for adult and adolescent sex offenders and victims. Overall, two interventions (Trauma-Focused Cognitive Behavioral Treatment [CBT] and Adult Child Molester Therapy) received substantial empirical support and posed little risk to the client. These treatments can be utilized specifically with juvenile sex offenders and victims; however, process and outcome evaluations should be conducted to help ensure that juvenile sex offenders and victims are receiving adequate and client-centered services.

Since this 2004 analysis, additional studies have documented the effectiveness of using Multi-Systemic Therapy (MST) in treating adolescent sex offenders. Using a factorial design with random assignment of youth to different treatment conditions, Letourneau and associates compared MST therapy to “treatment as usual for juvenile sex offenders” (hereafter TAU). TAU interventions included treatments with a cognitive behavioral orientation and focus on individual (youth-level) behavioral drivers. TAU interventions were delivered in weekly group treatment sessions for at least a year (Letourneau et al., 2009: 91). They used a sample of 127 youth and families who were recruited to the study based on referrals to a program. The research team found that youth who participated in MST reported significant reductions in sexual behavior problems, delinquency, substance use, mental health symptoms, and out of home placements.
### Child-Focused Interventions

<table>
<thead>
<tr>
<th>Treatment Protocol</th>
<th>Theoretical Basis</th>
<th>Clinical-Anecdotal Literature</th>
<th>Acceptance/Use in Clinical Practice</th>
<th>Potential for Harm Risk/Benefit Ratio</th>
<th>Empirical Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma-Focused CBT</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>1</td>
</tr>
<tr>
<td>CBT for Children with Sexual Behavior Problems</td>
<td>CBT-Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Dynamic Play Children with Sexual Behavior Problems</td>
<td>Dynamic-Novel</td>
<td>Little</td>
<td>Limited use</td>
<td>Some Risk</td>
<td>3</td>
</tr>
<tr>
<td>Cognitive Processing Therapy (CPT)</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Eye Movement Desensitization and Reprocessing (EMDR)</td>
<td>Novel/Reasonable</td>
<td>Substantial</td>
<td>Some Use</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Child/Parent Physical Abuse CBT</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Resilient Peer Training Intervention</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Therapeutic Child Development Program</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Trauma-Focused Integrative-Eclectic Therapy</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Trauma-Focused Play Therapy</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>4</td>
</tr>
</tbody>
</table>

**FAMILY, PARENT-CHILD, PARENT-FOCUSED INTERVENTIONS**

<table>
<thead>
<tr>
<th>Treatment Protocol</th>
<th>Theoretical Basis</th>
<th>Clinical-Anecdotal Literature</th>
<th>Acceptance/Use in Clinical Practice</th>
<th>Potential for Harm Risk/Benefit Ratio</th>
<th>Empirical Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Parent Training</td>
<td>Sound</td>
<td>Some</td>
<td>Some use</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Family Focused, Child Centered Treatment</td>
<td>Novel/Reasonable</td>
<td>Some</td>
<td>Some use</td>
<td>Some Risk</td>
<td>3</td>
</tr>
<tr>
<td>Multisystemic Therapy (MST)</td>
<td>Sound</td>
<td>Little with child abuse</td>
<td>Limited use</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Parent-Child Education/Physical Abuse</td>
<td>Sound</td>
<td>Substantial</td>
<td>Some use</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Parent-Child Interaction Therapy</td>
<td>Sound</td>
<td>Some</td>
<td>Some use</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Physical Abuse Family Therapy</td>
<td>Sound</td>
<td>Little</td>
<td>Limited use</td>
<td>Little Risk</td>
<td>3</td>
</tr>
<tr>
<td>Attachment-Trauma Therapy</td>
<td>Novel/Reasonable</td>
<td>Some</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>4</td>
</tr>
<tr>
<td>Family Resolution Therapy</td>
<td>Novel/Reasonable</td>
<td>Some</td>
<td>Some use</td>
<td>Some Risk</td>
<td>4</td>
</tr>
<tr>
<td>Treatment of Dissociative Symptomatology</td>
<td>Novel/Reasonable</td>
<td>Some</td>
<td>Some use</td>
<td>Little Risk</td>
<td>4</td>
</tr>
<tr>
<td>Intensive Family Preservation</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Little Risk</td>
<td>4</td>
</tr>
<tr>
<td>Parents United</td>
<td>Novel/Reasonable</td>
<td>Some</td>
<td>Some use</td>
<td>Some Risk</td>
<td>4</td>
</tr>
<tr>
<td>Parents Anonymous</td>
<td>Novel/Reasonable</td>
<td>Some</td>
<td>Some use</td>
<td>Some Risk</td>
<td>4</td>
</tr>
<tr>
<td>Corrective Attachment Therapy</td>
<td>Questionable</td>
<td>Little</td>
<td>Limited use</td>
<td>Substantial Risk</td>
<td>6</td>
</tr>
</tbody>
</table>

**OFFENDER INTERVENTIONS**

<table>
<thead>
<tr>
<th>Treatment Protocol</th>
<th>Theoretical Basis</th>
<th>Clinical-Anecdotal Literature</th>
<th>Acceptance/Use in Clinical Practice</th>
<th>Potential for Harm Risk/Benefit Ratio</th>
<th>Empirical Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Child Molester Therapy</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Some Risk</td>
<td>2</td>
</tr>
<tr>
<td>Adolescent Sex Offender Therapy</td>
<td>Sound</td>
<td>Substantial</td>
<td>Accepted</td>
<td>Some Risk</td>
<td>3</td>
</tr>
</tbody>
</table>

Comorbidity Problems

Positive outcomes can be achieved for a broad range of children with sexual behavior problems using short-term, outpatient cognitive behavioral treatment approaches. Such results have been found for both aggressive and less aggressive sexual behaviors, as well as for both boys and girls. Research has found that treatment modality (group versus individual sessions) is less critical to successful outcomes than the treatment approach (Chaffin et al., 2008).

Many youth with sexual behavior problems present with comorbidity. In these cases, blended CBT treatments designed to target sexual behavior and comorbid problems can be successful in reducing subsequent relapse. Children with serious traumatic stress symptoms should receive trauma-focused cognitive behavioral interventions that include added sexual behavior problem components. Chaffin et al. (2008) identify a broad array of well-supported models for addressing the needs of children with SBP and comorbidity including: Parent-Child Interaction Therapy (Brestan & Eyberg, 1998); The Incredible Years (Webster-Stratton, 2005); Barkley’s Defiant Child Protocol (Barkley & Benton, 1998), or the Triple-P program (Sanders, Cann, & Markie-Dadds, 2003) (Chaffin et al., 2008, p. 209).

Treatment Components

Effective treatment interventions target the risks and needs of the child, and integrates the family or primary caregiver in the treatment process. Chaffin et al. (2008) set forth a number of treatment components for serving children with sexual behavior problems. They note that treatment should include:

- An understanding that children do not possess the requisite cognitive maturity or ability for emotion regulation necessary to achieve emotional or behavioral control through self-understanding.
- Teaching young children concrete rules about sexual behavior and physical boundaries such as, ‘do not touch other children’s private parts.’
- Demonstration for young children, as they learn better from modeling, practice and reinforcement of behaviors across settings.
- Identification and recognition of the inappropriateness of rule-violating sexual behaviors that occurred in the past.
- Age-appropriate sexual education.
- Coping and self-control strategies.
- Basic sexual abuse prevention and safety skills.
- Social skills (p. 211).
Parent/Caregiver Treatment Components

The importance of integrating the child’s parents and/or caregivers in the treatment process cannot be overstated.

Treatment should teach parents, teachers, and caregivers practical behavior management and relationship improvement skills (Patterson, Reid, & Eddy, 2002) including how to: give clear behavioral directions to children, acknowledge positive child behaviors, use specific labeled praise for desired behavior, use time-outs with younger children, use logical and natural consequences with older children, and promote parental/caregiver consistency, warmth and sensitivity (Chaffin et al., 2008).

Chaffin and colleagues (2008) have identified a number of treatment interventions for parents and caregivers including:

- The development and implementation of a safety plan which includes a supervision and monitoring plan, communication with other adults (such as day care and extended family) about supervision needs, and modifications to the safety plan over time in accordance with improvements in behavior.
- Information about sexual development, normal sexual play and exploration, and how these differ from childhood sexual behavior problems.
- Strategies to encourage children to follow privacy and sexual behavior rules.
- Identification of factors that contribute to the development and maintenance of sexual behavior problems (e.g., an environment that is overly sexually stimulating for the child).
- Sex education and how to listen and talk with children about sexual matters.
- Parenting strategies for building positive relationships with children and addressing behavior problems including learning and practicing skills, redirection, giving clear directions, and consistent application of rules and discipline.
- Techniques for supporting children’s use of self-control strategies they have learned.
- Information on relationship building and setting appropriate boundaries for physical affection with children.
- Strategies to guide children toward positive peer groups, which in turns can increase pro-social, protective factors for the child.

Treatment Setting

As has been documented through the research discussed here, positive outcomes can be achieved for many children with sexual behavior problems through the use of short-term, outpatient interventions that do not require removal of the child from the home setting. Great care should be taken in removing children from the home, as this can confound the child’s problems and inhibit successful outcomes, as well as effective caregiver integration in the treatment process. The selection of
the treatment setting requires careful case-by-case assessment. While retaining children in the home should be the first priority, out-of-home placements may be necessary in those cases where retaining the child in the home may cause harm or significant distress to other members of the home, when reasonable efforts to restrict sexual behavior problems have not been successful, and when there is a lack of reasonable efforts to provide a healthy environment for the child and the sexual behavior problems persist. These should be the exception and not the norm, and removal should be short-term if at all possible (Chaffin et al., 2008).

In those circumstances where a child has sexually victimized another child in the same home and out-of-home placement is not deemed necessary, caregivers can:

- Have the child with sexual behavior problems stay near the caregiver, teacher or child care worker during nap times.
- Avoid leaving the child alone with other children in the bathroom or changing areas.
- Provide appropriate reinforcement for keeping hands to himself/herself.
- Educate teachers, staff, caregivers that “SBP are not uniquely difficult behaviors to correct and that most children with SBP will desist from the behavior given appropriate guidance, structure, and help” (Chaffin et al., 2008, p. 209). As Chaffin et al. (2008) note, this may help to prevent having the child excluded from these settings, which could cause additional disadvantage and risk.

Policy Implications

The findings from these studies on treatment interventions for children with sexual behavior problems and adolescent sex offenders have significant policy implications. In particular, the use of community-based and family-focused interventions for youth who engage in sexual offending is supported by the research (Letourneau et al., 2009; Saunders et al., 2004). Use of cognitive-behavioral treatment approaches is likewise supported by these studies, as is the documentation of similarities in risk factors between adolescent sex offending and other types of serious antisocial offending. Decreased attachment to family and school, as well as association with deviant peers, are relevant risk factors for adolescent sex offenders and delinquent youth in general (Ronis and Borduin, 2007). As such, interventions should target “multiple ecological systems” impacting the lives of youth involved in sexual deviance (Letourneau et al., 2009:99).

Public fear of and disdain for child victimization and sex offenses is pronounced. In recent years, states and the federal government have moved to implement public sex offender registration and notification for not only adult sex offenders but also children who commit sexual offenses. In many ways, despite empirical evidence to the contrary, there is a presumption that sex offenders are intransigent, compulsive and incurable.
With recent legislation such as the Adam Walsh Act, public policy is increasingly stigmatizing and isolating young sex offenders far more than adult criminals and at ages as young as 14 years (stigmatizing and labels which will remain with the child for their entire lives) (Zimring, 2004). Yet, research findings have consistently demonstrated relatively low risk levels for sexual reoffending among children found to have sexual behavior problems or who have sexually offended (Carpentier et al., 2006). This has led some to conclude that ‘public policies for these youth have been fundamentally driven by misperceptions, resulting in a set of well-intentioned but ultimately flawed policies and practices that are unlikely to deliver either child protection or juvenile justice benefits’ (Chaffin, 2008, p. 110).

DISCUSSION AND SUMMARY FINDINGS

Empirical research on child-on-child sexual abuse is its early stages in comparison to studies of adult sexual offending. Analyses of adolescent sexual deviance suggests that there may be significant differences between youth and adult sex offenders in terms of risk factors, risk to re-offend, and the efficacy of treatment interventions. As such, it is critical that screening instruments and risk assessments be tailored to juveniles and adolescent development.

Treatment interventions based on cognitive-behavioral therapy demonstrate the greatest effectiveness to date in addressing the risks and needs of adolescents who engage in child-on-child sexual abuse. Future research should seek to validate individual treatment programs and assessments for adolescent sex offenders. All new and/or modified programs should be empirically assessed at implementation and outcomes should be examined to determine relative effectiveness in reducing subsequent offending.

Overall, the research literature to date has explored child-on-child sexual abuse in terms of characteristics and risk factors, assessment, and treatment interventions. A summary of each of these areas is presented below and citations referenced earlier apply accordingly.

Characteristics and Risk Factors of Children with Sexual Behavior Problems

- Children with sexual behavior problems are not a homogeneous group. Researchers have set forth the following general definitional age criteria for adolescent sex offenders:
  - Child molesters: perpetrators who are more than 5 years older than their victim; and
  - Peer offenders: perpetrators who are within five years of age of their victim.

- Various typologies have been proposed to classify youths who engage in risky sexual behavior; however, the categories often overlap and are overly complex, suggesting that
ineffectiveness of taxonomic classification.

- Children with SBP may be subject to a wide range of negative personality traits, problem behaviors, and a history of family instability.

- Female adolescent sex offenders are quite different from their male counterparts, as they are more likely to be exposed to sexual abuse, have an earlier age at onset, and are more likely to have witnessed prior trauma.

- Risk factors identified in the research include: prior sexual abuse, exposure to domestic violence, association with negative peers, hostile and aggressive behavior, and mental health issues.

- Studies have identified a number of risk factors positively associated with the likelihood to reoffend among juvenile sex offenders including: 1) a child or adult victim, as opposed to a peer victim; 2) the use of threats or weapons in the commission of sex offense(s); 3) prior sex offenses; 4) a male victim, as opposed to a female victim; 5) older offender intake age; and 6) having prior non-sexual offenses.

- Children who engage in sexual offending are developmentally, cognitively and fundamentally distinct from adult sex offenders.

- Victims often exhibit symptoms of depression, Post-Traumatic Stress Disorder (PTSD), and sexual acting out behaviors.

- Other indicators of victimization may include suicidal ideation, running away, truancy, and substance abuse.

**Identification and Assessment**

- Evidence suggests that ecological assessments that consider the child’s prior abuse history, environment, school, family, and social/economic factors are most effective in addressing the underlying issues and treatment needs of children with sexual behavior problems.

- A number of relatively easy-to-administer assessment instruments appropriate for children 12 years and younger were discussed including the Child Sexual Behavior Checklist (CSBCL), Child Sexual Behavior Inventory (CSBI) and the Weekly Behavior Report (WBR).

- The Impulsive/Antisocial Behavior scale of the JSOAP-II and the interpersonal and antisocial factors of the Psychopathy Checklist: Youth Version (PCL:YV) significantly predict future sexual recidivism.

**Victim Characteristics and Risk Factors**

- There are few empirically sound studies which assess victim characteristics.

- Victims are most often female.
Children with sexual behavior problems present with many similar risk factors to other serious youthful offenders, as such evidence-based practices for at-risk youth should be employed with this population.

- Treatment should be holistic and address the multiple ecological factors present.
- Cognitive-behavioral interventions have demonstrated success in relapse prevention and recidivism reduction.
- Trauma-Focused Cognitive Behavioral Therapy (CBT) and Adult Child Molester Treatments have received substantial support as effective treatment interventions for adolescent sex offenders.
- Multi-systemic Therapy (MST) has likewise demonstrated recent significant outcomes in reducing sexual behavior problems, delinquency, substance use, mental health symptoms, and out-of-home placements among youths who have engaged in sexual offending.

More research is necessary in order to further develop effective program models. Reports of juvenile sex offending have increased substantially in recent years. However, the recent increase in statistics may not be due to an actual increase in the number of offenses per se but an increase in the number of reports to the police.

While official statistics are necessary to determine trends in arrest rates, self-reports of juvenile sex offending may be more problematic in capturing the frequency of the crime. This is in large part due to the fact that the subject is a child and the act being reported is sensitive in nature. Self report studies may help to establish a baseline against which to compare trend levels of official statistics. More generally, the field on child-on-child sexual abuse is growing in terms of empirical studies documenting offender and victim characteristics, as well as research on the efficacy of treatment interventions. Large scale, statewide efforts such as the Florida Department of Children and Families’ Child-On-Child Sexual Abuse Needs Assessment represents a significant positive step toward effectively serving this population of at-risk adolescent offenders and victims.
REFERENCES


