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Child Maltreat 2008; 13; 110

DOI: 10.1177/1077559508314510

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<http://cmx.sagepub.com/cgi/content/abstract/13/2/110>

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Our Minds Are Made Up—Don't Confuse Us With the Facts: Commentary on Policies Concerning Children With Sexual Behavior Problems and Juvenile Sex Offenders

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This commentary examines four common policy-relevant perceptions of teen and preteen sex offenders—high risk, “specialness,” homogeneity, and intransigence. Each perception is contrasted with long-standing as well as more current scientific facts. It is argued 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. These include federal and state policies pertaining to public registration and notification, community management, institutional placement, treatment approaches, and treatment standards. The research evidence about these juveniles is considerably more positive than current policies or clinical practices might suggest, and reflects a sharp disconnect between popular policy-relevant perceptions and the facts as we know them about these diverse cases.

Keywords: *juvenile sex offenders; policy*

It used to be, everyone was entitled to their own opinion, but not their own facts. But that's not the case anymore. Facts matter not at all. Perception is everything.

– Stephen Colbert in a January 26, 2006, interview about *truthiness*, a word he coined to parody political arguments based on gut feelings to the exclusion of, or contradicting, facts and data. As a sign of the times, *truthiness* was accorded Word of the Year honors in 2005 and 2006.

CHILD MALTREATMENT, Vol. 13, No. 2, May 2008 110-121
DOI: 10.1177/1077559508314510
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The simple truth is that juvenile sex offenders turn into adult predators. . . . I want to challenge you to look deep down inside. Isn't it time to put our kids' safety before the rights of sexual offenders, adult or juvenile? When is enough going to be enough? Must we have even one more Jessica Lunsford or one more Sara Lunde?

– Testimony given by a 17-year-old before the U.S. Congress in 2005 advocating for placing children and teenagers on public sex offender registries and notifying their communities about them. A law was named after the 17-year-old and passed as part of the Adam Walsh Act of 2006, and is beginning to come into effect. Fourteen-year-olds will soon be subject to the same lifetime public labeling and restrictions as the most serious adult sexual predators.

It is difficult to imagine a more reprehensible crime than the sex murder of a child. Child victims such as Jessica Lundsford and Sara Lunde, mentioned in the quote above, and Adam Walsh have touched the hearts of many. These thankfully rare but tragic crimes are heartbreaking, frightening, and infuriating. We want justice for the victims. We want to do something to prevent similar tragedies from happening again. We want to do something to prevent sex crimes against children in general. Seeking to protect children from sex crimes is an entirely good and appropriate policy objective. But heartbreak,

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fear, and anger do not necessarily generate good child protection policy. Good policy requires accurate facts, not just rallying cries and single-case testimonials. It is not enough to be well intentioned or to simply look deep down inside. We must first be well informed and then think rationally, not emotionally, about the problem we hope to solve.

In 1998, as part of a special issue of *Child Maltreatment* focused on juvenile sex offenders and children with sexual behavior problems, Barbara Bonner and I authored a commentary titled "Don't Shoot, We're Your Children: Have We Gone Too Far in Our Treatment of Adolescent Sexual Abusers and Children With Sexual Behavior Problems" (Chaffin & Bonner, 1998). Now, a decade later, I was invited to author a reprise of the commentary on the occasion of this special issue dedicated to Bill Friedrich, a deeply missed advocate for scientifically sound practice and policy. The 1998 commentary voiced the opinion that treatment approaches for these youth were fundamentally founded on a set of unproven assumptions drawn from theories about adult pedophilia. We argued that these untested assumptions, which had shaded into rigid dogma, had led to juvenile treatment practices that were a mismatch for children and teens.

In essence, the article argued that our treatment responses to the problem of juvenile sex offenses showed signs of having "gone too far." Efforts during the 1980s had succeeded in rallying needed attention to the real and long-minimized social problem of juvenile-on-juvenile sex crimes. But in doing so, we had begun to embrace a set of harsh treatment practices based on unproven assumptions. We emphasized how there was a lack of scientific data to inform the conventional wisdom of the day about juvenile sex offender treatment techniques, most of which presumed that juvenile-on-juvenile sex crimes reflected a compulsive and incurable pattern of deviant sexual arousal and calculated deceit similar to characterizations of adult sexual predators. There were disturbing signs on the horizon that these untested treatment assumptions were making inroads into public policy in ways that could ultimately harm children and youth.

Now, 10 years later, circumstances have changed. Some developments are definitely for the better. Unfortunately, several appear to be for the worse. The good news is that the facts, by which I mean scientific data, are considerably more robust and lend themselves to firmer conclusions. The bad news is that the facts have hardly mattered at all in the public policy arena. Public policy has continued to move in the directions feared in 1998, despite an increasing accumulation of data that suggest that the

reasons cited to justify these policies are no longer merely unproven or unexamined assumptions, but are flatly at odds with the facts as we know them. In 1998, we commented on the gap between what was actually known and what was assumed. A decade later, this has evolved into a polarization between facts and perceptions. The question now is not whether we have gone too far—that point was passed long ago. The question now is when or how we will find our way out, and how many children and youth may be needlessly harmed before rational, fact-based policies and practices supersede the minimization of our past and the moral panic of the present.

Perhaps the best place to start is with the facts, by which I mean reasonably rigorous scientific data and not speculative theories, clinical lore, police lore, personal stories, testimonials, or political ideologies. As the articles in this issue illustrate, the body of facts about children with sexual behavior problems has grown considerably. This is especially true in the area of intervention knowledge. There have been multiple randomized clinical trials testing intervention outcomes among children with sexual behavior problems. Treatment outcome studies have been summarized meta-analytically to identify individual intervention elements associated with better outcomes. In addition to data about whether treatment reduces downstream sex crimes and behavior, we now have data on which individual treatment elements appear to most strongly predict behavior change. There has been lesser but still substantial growth in knowledge about teenage sex offenders. Many missing pieces of the factual puzzle cited in our 1998 article are now far clearer. For example, more is known about the heterogeneity and subgroup composition of teenage sex offenders; there are improved epidemiologic data; more is known about actuarial individual risk prediction; and more is known about the relative rates of subsequent sex crimes for both teenage sex offenders and children with sexual behavior problems compared to other groups of children and teens with no documented history of sexual perpetration or sexual misbehavior. Initial randomized trial findings supporting the use of multisystemic therapy with adolescent sex offenders have been replicated, and a third randomized trial is nearing completion. A number of follow-up studies done with teenage sex offenders have supported earlier recidivism findings, and have helped place these rates in context by comparing them with other groups of delinquent youth. Early evidence is accumulating about the intended and unintended impact of public registration and notification. In the sections that follow, both long-established and newer

facts will be examined to illustrate four critical policy-relevant misperceptions about these youth.

MISPERCEIVED RISK

The available facts suggest that children with sexual behavior problems, as a group, pose a *low* long-term risk for future child sexual abuse perpetration and sex crimes. Much the same could be said about teenage sex offenders as a group, for whom low future sex offense and sexual abuse perpetration rates have been well established (Alexander, 1999; Caldwell, 2002). For teenage sex offenders, the low-risk news is not new—decades of U.S. studies typically report long-term future sex offense rates in the range of 5%-15% (the lower end of this range more often characterizing those who complete some sort of treatment program, and the higher end more often characterizing those who do not). The sole long-term follow-up study of preteen children with sexual behavior problems found even lower long-term rates (2%-10% at 10-year follow-up depending on type of treatment received; Carpentier, Silovsky, & Chaffin, 2006). In fact, treated children with sexual behavior problems are as likely to be future sex abuse *victims* as future sex abuse *perpetrators*. In both cases, teen and preteen, the facts are fairly consistent and point in one direction—low long-term risk. Defending the national lifetime juvenile sex offender registration policies of the new Adam Walsh Act in an ABC News interview, the U.S. Justice Department official in charge of implementing the law stated that scientific findings about juveniles were inconclusive and “all over the board” (Rogers, quoted in Michels, 2007). It is difficult to know whether this statement is disingenuous or simply misinformed. In any case, it hardly reflects the facts on risk as we know them. The fact is that low future sex crime rates among juvenile sex offenders in the United States are a well-replicated, robust, and long-standing scientific finding. The long-term risk among children with sexual behavior problems appears to be even lower, especially given correct treatment.

So why has the perception of high risk persisted and the facts about low risk remain largely ignored? Some individuals may prefer the perception of high risk to legitimize their hunger for retribution against sex crimes. A less purposeful explanation might lie in the confusion between retrospective and prospective data, and the logical fallacy of “backwards reasoning.” It is well known that, retrospectively, a significant number of adult sex offenders date the onset of their behavior to childhood or adolescence (Marshall, Barbaree, & Eccles, 1991). By reasoning

backwards, some might erroneously conclude that most children with sexual behavior problems and most teenage sex offenders therefore will persist in committing sex crimes and require management or containment approaches similar to those used with adult predators. This is analogous to reasoning that because many chronic heroin addicts began their drug-using careers as teen marijuana smokers, adolescents caught smoking marijuana should therefore be placed on a lifetime methadone program.

Others may doubt that the recidivism data are accurate. The common, indeed almost reflexive, objection raised is that sex crimes are underreported and therefore the actual number of recidivists is many, many times the number reflected in the official recidivism data. There is little doubt that sex crimes often go unreported. But there are a number of considerations that make underreporting less of a factor than it might ostensibly seem. Even if underreporting is a large factor for isolated events, it can become a small factor in recidivist counts for a repetitive behavior. The odds of a *single* sex crime being reported may be low, but the *cumulative odds* that someone will evade *all* detection for a repetitive behavior decreases exponentially with the number of events. The odds are likely to catch up with recurrent offenders, unless they are masters at evading detection. Given that children with sexual behavior problems and teenage sex offenders are detected committing a high number of nonsexual offenses (primarily property crimes and drug crimes) and, like most other juveniles, tend to be more clumsy than artful in their delinquent actions, they do not fit the bill as skillful masters of evasion. Data are available from numerous studies that have followed these children and youth for long periods of time—a decade or longer—using multiple data sources. The recidivism hazard rates observed in these studies typically decline quickly over time, and have dropped close to zero after 2 to 4 years. Consequently, it is not unreasonable to conclude that the studies have captured a significant portion of true recidivists. But the most persuasive facts supporting low risk come from more recent studies—those that have used comparison groups to track future sex offense rates. These will be addressed in the next section.

MISPERCEIVED “SPECIALNESS”

Often, future sex offense rates among children with sexual behavior problems or teenage sex offenders are interpreted as if these are the only juvenile populations having any future sex offense risk. This is plainly false. Ordinary youth have some

nonzero risk to commit a sex offense. Determining what is an unacceptably high risk is not simply a matter of the absolute risk rate but also the relative risk rate and requires answering the question, "High risk compared to what?" Unlike the bulk of earlier studies that examined risk without the advantages of comparison groups, more recent studies have included reasonably matched (i.e., drawn from the same sectors of society) comparison groups with no known history of illegal or norm-violating sexual behavior. This provides an interpretative context which is lacking in single-group studies. For the sake of example, let us assume that 5% of children and teens completing credible treatment for sexual behavior problems ultimately are found to commit a future sex offense. Some might argue that even this rate is unacceptably high compared to zero, and that "it is better to be safe than sorry" or to "err on the side of protecting victims." But is 5% really too risky in the context of what is ordinary for other groups of youth? We presume that youth with the sex offender label pose an extraordinarily high, perhaps even uniquely high, risk relative to other groups. This is the presumptive foundation for many current policies—after all, if we are going to warn the public, we need to warn them about people who are unusually or extraordinarily dangerous, not about people posing fairly ordinary risk levels.

Many policies are themselves risky—this is why the justifications of better safe than sorry and err on the side of victims are overly simplistic and misguided. Both heuristics presume that there is no downside to the policy in terms of child protection or community safety—only the burdens placed on offenders or offender's rights need to be balanced against the potential good done by the policy (e.g., "Isn't it time to put our kids' safety before the rights of sexual offenders, adult or juvenile?"). The potential community safety risks of policies such as public notification are fairly easy to see. Placing youth on lifetime public registries creates both direct stigmatization and can set in motion a series of cascading policy effects resulting in social exclusion and marginalization. In addition to the obvious social and psychological fallout due to public stigmatization, registered individuals may be subject to related laws and public policies including residency restrictions, employment restrictions, special flagging as a "sex offender" on driver's licenses, automatic expulsion from public schools, and so forth. For example, in jurisdictions where broad sex offender registration and strict residency restriction policies exist and are linked, there are reports of growing numbers of individuals pressed into lives of homelessness and segregation

into sex offender "colonies," including those labeled as sex offenders on the basis of behavior they committed years earlier as young teens (Thompson, 2007).

Permanent stigmatization and exclusion from society are opposite from the ways our juvenile justice system handles other types of serious juvenile offenses. Juvenile records normally are protected from public exposure and the focus is on bringing youth more into the prosocial mainstream rather than excluding them from it. There are good public safety reasons for not turning children and youth into pariahs, in addition to the fairly obvious moral and human rights arguments that could be made. Crime is more likely to occur when bonds with mainstream society are weakened—that is, when individuals lose or fail to develop social anchors such as school involvement, stable employment, stable residence, military service, job advancement, engagement with prosocial institutions, becoming a part of prosocial friendship networks, fitting into a neighborhood, having prospects for marriage or committed relationships, and raising a family (Sampson & Laub, 2005). It is during adolescence and early adulthood that life-course tipping points for these social anchors are met and a future life direction is steered. Serious stigmatization and marginalization diminish the prospects for healthy social anchors and can set a course for criminal behavior as well as numerous other problems. Normally, we believe it is in everyone's interest to stigmatize and isolate juvenile delinquents *far less* than we do adult criminals. For young delinquents labeled as sex offenders, we have now decided to stigmatize and isolate them *far more* than we do most adult criminals—indeed, we are now going out of our way to stigmatize and exclude them to an extent unprecedented in modern juvenile justice history (Zimring, 2004). It is not necessarily that we are ignorant of the risks brought on by stigmatizing and isolating youth or that all proponents of these policies just thoughtlessly bloodthirsty or uninformed, but rather that we are willing to impose these burdens and take this risk because we perceive these groups of youth to be so extraordinarily dangerous compared to other delinquent or behavior problem youth that correspondingly extraordinary steps are warranted. The data suggest that the perception of extraordinary danger forming the foundation for these policies is factually false for both teens and preteens.

Carpentier et al. (2006) followed children with aggressive sexual behavior problems for over a decade, comparing two randomized treatment intervention groups. More importantly, the study used the same follow-up techniques for a third group of general

outpatient clinic children with no history of atypical sexual behavior. Most of these children had common behavior problems such as attention deficit hyperactivity disorder (ADHD) or learning problems in school. Nobody would view children with ADHD or learning problems as an unusually sexually dangerous class. Nobody is proposing placing children with ADHD on lifetime sex offender registries, subjecting them to residency restrictions, forcing their families to relocate, flagging their driver's licenses, limiting their employment opportunities, segregating them from other children, or automatically expelling them from public schools. To even suggest such a policy on the basis of sex crime risk would rightly seem bizarre. Yet, at a 10-year follow-up, the rate of sex abuse perpetration reports among former children with sexual behavior problems who received brief, focused treatment was no different from that found among general outpatient clinic children with ADHD (2%-3%). In other words, the long-term sex crime risk of appropriately treated children with sexual behavior problems was no different from that of children for whom we would never consider extraordinary and burdensome community protection measures. No public notification policies were in effect in the state where the study was conducted, so these sorts of containment policies could not have suppressed offense rates for the sexual behavior problem group.

The first implication of this finding concerns the ubiquitous underreporting objection raised regarding the accuracy of future sex offense rates. There is little reason to expect that underreporting would operate differently between groups. This allows us to determine whether risk is relatively high irrespective of any underreporting bias. Given credible intervention, long-term sex crime risk among former children with sexual behavior problems is not much different from other, far larger and more general groups of children. On the basis of this, we can conclude that their long-term sex crime risk is ordinary, not extraordinary. This is not to suggest that sexual behavior problems do not require some intervention in the short term, but rather that once appropriate short-term efforts are initiated, long-term outcomes become fairly ordinary.

Similar findings have been reported among teenagers. Caldwell (2007) conducted a large sample study of incarcerated teenage sex offenders, comparing their recidivism to that of general nonsexual delinquents from the same or similar juvenile justice facilities. Both groups were released from custody in the same state at about age 17 and followed for 5 years. Seven percent (7%) of the adjudicated teen

sex offenders had a subsequent sex offense. So did 6% of the adjudicated *nonsexual* delinquents. The difference was not statistically significant. Again, there was no widespread juvenile sex offender public notification policy in effect during the time frame of the study, so we can rule out that this might have suppressed recidivism for the sex offender group.

Although the juvenile sex offender groups and the comparison groups in these studies had comparable future sex offense rates, it is important to note that the groups are not comparable in size. There are vastly more children with ADHD or learning problems than children labeled as having sexual behavior problems. There are vastly more nonsexual than sexual teen delinquents (e.g., sex offenses make up a small percentage of all delinquency cases in juvenile courts; Snyder & Sickmund, 2006). Consequently, the total number of future sex offenses attributable to these (and probably many other) comparison groups will be correspondingly large—vastly larger than the number attributable to youth officially labeled as juvenile sex offenders. In fact, this is what Caldwell (2007) found: 85% of all future sex crimes committed by the entire released juvenile delinquent population were committed by former *nonsexual* delinquents, including *all* 3 sex homicides as well as *all* 54 homicides.

The gut emotion provoked by the specter of another Jessica Lundsford or another Sara Lunde is powerful—powerful enough make many overlook the embedded false presumptions and misperceptions. But the fact of the matter is that when these sorts of tragic but thankfully rare events happen again, they are far more likely to be at the hands of someone other than a previously labeled teenage sex offender or child with sexual behavior problems. Consequently, singling out these children and youth for dire public warnings, lifetime stigmatization, and social exclusion cannot possibly prevent much of it. It is doubtful that whatever speck of prevention might be achieved will even be enough to offset the increased risk we will create as a result of isolating and stigmatizing these youth for long and developmentally important periods of their lives, raising the very real possibility that we are not only harming youth needlessly but also doing more harm than good when it comes to community protection.

These facts raise a fundamental question about the juvenile provisions of the Adam Walsh Act and those of many states. If juvenile public notification policies are unlikely to deliver real community protection, then what justification remains for these policies? There are other justifications that could be offered—justifications that are not so easily amenable to scientific

evaluation, such as satisfying a public desire for retribution, as just deserts for bad acts, as a testament to our anger and disgust over sex crimes in general, or as making a public example of some children and teens to deter others. These functions are occasionally offered by proponents to justify these policies and may be their sole de facto functions. In other words, it appears that our laws placing broad groups of juveniles on lifetime public sex offender registries are exclusively punitive policies, not community protection policies, and therefore should be evaluated legally for their appropriateness as punishment rather than as community protection.

Other misperceptions of specialness can be seen in the clinical treatment sphere, although this has begun to change over the past decade. The old clinical lore viewing children with sexual behavior problems and teen sex offenders as “incurable” or as “junior pedophiles” is fading. Many treatment opinion leaders have articulately repudiated the adult sex offender treatment model adapted downward to children and teens (Letourneau & Miner, 2005; Longo & Prescott, 2006). In some instances, this has led to genuine and substantive reformulation of treatment models. It also has led to far more selective application of some techniques (e.g., masturbatory reconditioning or covert sensitization) that are now recommended rarely and only in selected individual circumstances rather than categorically. But other adult model techniques persist and continue to be applied on a large scale in the field. Treatment providers may paradoxically state their rejection of the adult model adapted downward to juveniles, though still routinely employing treatment techniques directly derived from it, apparently unconcerned or unaware that the roots of the techniques being used lie directly in the assumptions ostensibly being repudiated. Many juvenile sex offender treatment programs are operated by providers with backgrounds in adult sexual deviancy, not by providers with backgrounds in modern evidence-based child behavior problem or teen delinquency interventions. When it comes to grasping misapplication of the adult sexual deviancy model, their backgrounds may not allow them to see the forest for the trees. Adult model techniques that are still routinely applied include the popular offense cycle and relapse prevention approaches that form the core of most juvenile programs. It also includes the obsession with flushing out presumed hidden deviancy and extracting escalating and questionable confessions of deviant thoughts and tendencies via polygraph interrogations, masturbation logs, fantasy journals, or other suggestive and coercive techniques of doubtful

accuracy, untested benefit, and considerable potential for harm and self-confirmatory bias. These are the elements that make up “sex offender–specific” treatment as mandated by juvenile justice policy in some states, even as these same policies ostensibly repudiate viewing juveniles as simply younger versions of adult pedophiles or predators. It would appear that the sea change in juvenile sex offender treatment is only just getting started.

The fundamental misperception reflected in traditional juvenile sex offender–specific treatment is that of differentness or specialness. In other words, children with sexual behavior problems and teen sex offenders are perceived as behavioral “specialists,” different from other child or teen behavior problem groups, with deeply seated, deviant motivations requiring unique and esoteric treatments known only to a few sexual disorder specialists and deliverable only within the confines of specialized facilities or programs. Unlike virtually every other juvenile delinquent and childhood behavior problem group, sex offending youth are not viewed as “generalists” whose versatile and episodic problem behaviors reflect broad, general problems with self-control, judgment, and social environment (see Gottfredson & Hirschi, 1994; Piquero, Moffitt, & Wright, 2007; Sampson & Laub, 2005). As discussed in the upcoming section on misperceived homogeneity, it is likely that either conceptualization (specialist or generalist) could be true for a given individual case, although the point here is that the specialist conceptualization currently is applied wholesale whereas the generalist conceptualization is probably more often true. Few doubt that compulsive adult pedophiles are a specialized category of offenders demanding specialist attention. But that same principle does not fit many or most juvenile sex offenders and children with sexual behavior problems.

The misperception of specialness has permeated virtually every aspect of service provision, service program funding, juvenile justice policy, and child welfare policy. In many jurisdictions, children with sexual behavior problems or teen sex offenders are required to be segregated within residential and outpatient treatment facilities into separate programs, and can only be treated by certified sex offender treatment staff. State policy and practice guidelines paint services for these youth as the exclusive province of select specialists to the point of establishing specialty licensure categories, practice restrictions, and certification requirements. Regular child and adolescent service providers have been taught to view sex offenders as beyond the pale of their capability and as cases they should automatically decline

to treat. Even when a youth with the sex offender label has decidedly nonsexual problems (which is very common, including problems such as ADHD, depression, substance abuse, or PTSD), he or she is routinely funneled to a sex offender specialist for treatment—much as one might always send a horse to a veterinarian rather than a pediatrician. A decade ago, specialness was an unproven assumption among providers. It is now codified in official policy and clinical lore. From an economic perspective, these policies secure client flow for specialized sex offender practices, and generate considerable business for the polygraph interrogation guild. However, clinical specialness has become a perception frequently at odds with the facts.

To what extent should these clients belong exclusively to sex offender treatment specialists, and to what extent could many be well served via more general evidence-based programming? The available facts suggest two answers to this question. First, the answer depends on the individual youth; and second, a broad swath of these youth clearly *can* be quite well served via more general approaches. Given that many general behavior disorder and delinquency treatment models have been better evaluated and are more scientifically refined than specialized sex offender-specific services, it is likely that many youth might be *better* served by evidence-based generalist programs, although direct comparisons have yet to be scientifically drawn. It has long been established that youth with sexual behavior problems commonly have other nonsexual problems and are many times more likely to have future crimes that are nonsexual in nature than sexual. Now there are additional and more directly relevant data from intervention research suggesting that effective treatment can be correspondingly general in focus.

A larger volume of clearer data exists for preteen children with sexual behavior problems. Randomized trials with preteen children having both sexual abuse-related PTSD and sexual behavior problems (a common combination) have found that short-term trauma-focused cognitive-behavioral therapy (TF-CBT) treatments that also teach parents child behavior management skills are effective in reducing sexual behavior problems (Cohen & Mannarino, 1997; Stauffer & Deblinger, 1996). The treatment used in these studies was an evidence-based trauma-focused treatment, not a sex offender-specific treatment adapted for children. In fact, it appears that adapted sex offender-specific treatment elements may even be counterproductive for children. As the St. Amand, Bard, and Silovsky (2008 [this issue]) meta-analysis found, the largest effect sizes for preteens

are not found among programs including adapted sex offender-specific elements, but among programs that teach parents general child management skills for enforcing behavior rules (sexual and nonsexual) and that teach *victimization* prevention skills. From the “generalist” perspective, this finding is completely predictable: teaching parents or caregivers structured behavior management skills is probably the single best supported intervention element for child and adolescent behavior problems (Brestan & Eyberg, 1998; Kazdin & Weisz, 1998; Reid, Patterson, & Snyder, 2002). Conversely, St. Amand et al. (2008) found that including the more decidedly “specialist” sex offender-specific elements in programs was associated with *reduced* benefits. This too is hardly surprising, given that many of these sex offender-specific approaches (e.g., teaching relapse-prevention chains) have not panned out to reduce recidivism even among the adult sex offenders for whom they were originally designed (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). Why should we expect them to work with children? When it comes to children, it is becoming more and more difficult to locate any baby hidden within the traditional sex offender-specific treatment model bathwater.

Among teenagers, the available data are more limited, but findings are beginning to point in a similar direction. Multisystemic therapy (MST), which is a generalist-oriented treatment designed for regular juvenile delinquents, has the strongest evidence of effectiveness among teen sex offenders of any current treatment model—far greater than the level of scientific support that exists for conventional sex offender-specific models. MST focuses directly on teaching parents skills for monitoring and managing their teen’s delinquent behavior, unlike most sex offender-specific models which focus on intrapsychic aspects of the individual teen’s presumed compulsive, cyclical, or stereotypic sexual behavior pattern. The problem, of course, is that in most cases no such compulsive, cyclical, or stereotypic pattern exists, except in the ideology of the treatment program and in policies or treatment standards mandating how treatment must be done.

In summary, there is reasonable evidence suggesting that a substantial number of these youth are generalists, not specialists, and that generally effective child and adolescent treatment approaches *can* work for many teen sex offenders and children with sexual behavior problems providing that they focus to some extent on the problem at hand and include evidence-based elements. Consequently, it is misguided for public policy to mandate that youth can *only* receive sex

offender-specific treatment delivered by sexual disorder specialists. Policies in some states have created barriers to the use of MST with juvenile sex offenders because it did not fit the dogma of sex offender-specific treatment, despite the fact that MST has amassed far stronger scientific support for delivering recidivism reduction outcomes. Improved policy should focus on making an array of well-matched services available to these youth rather than restricting them to sex offender-specific providers and modalities or mandating that all must receive sex offender-specific treatment.

MISPERCEIVED HOMOGENEITY

One of the likely culprits for some of the poor juvenile justice policies just discussed is the imprecision of the term *juvenile sex offender* itself. As a taxonomic category, the term has virtually no value other than as an administrative classification for crimes. Taxonomically, the term misleads more often than it informs. As we have seen in the prior discussion, it has little value as a risk marker, as a prognostic indicator, or prescriptively for intervention purposes. The problem is that youth captured under the sex offender label, although presumed to share common features, are actually incredibly diverse and may have little in common with each other aside from their administrative classification under law and policy. With few exceptions, policy and practice does not adequately reflect population diversity. Testimonials and case stories cannot capture it. Youth labeled as juvenile sex offenders include traumatized young girls reacting to their own sexual victimization; persistently delinquent teens who commit both sexual and nonsexual crimes; otherwise normal early-adolescent boys who are curious about sex and act experimentally but irresponsibly; generally aggressive and violent youth; immature and impulsive youth acting without thinking; so-called Romeo and Juliet cases; those who are indifferent to others and selfishly take what they want; youth misinterpreting what they believed was consent or mutual interest; children imitating actions they have seen in the media; youth ignorant of the law or the potential consequences of their actions; youth attracted to the thrill of rule violation; youth imitating what is normal in their own family or social ecology; depressed or socially isolated teens who turn to younger juveniles as substitutes for agemates; seriously mentally ill youth; youth responding primarily to peer pressure; youth preoccupied with sex; youth under the influence of drugs and alcohol; youth swept away by the sexual arousal of the moment; or

youth with incipient sexual deviancy problems. The list is lengthy and could easily be extended. The reality of population diversity is not new. It was the core feature of one of the earliest adolescent treatment schemes (O'Brien & Bera, 1986), and has been recognized by clinical researchers for decades (Becker, 1998). What is new is that this diversity now has stronger empirical support from the work of Hunter and colleagues (beginning with Hunter, Figueredo, Malamuth, & Becker, 2003, and extending forward), who have used more rigorous empirical methods to delineate broad subgroups among teen sex offenders, and from which we can deduce correspondingly different sets of intervention and management needs. Empirical classification efforts with preteen children suggest possibly even greater diversity. Given that population diversity now has better empirical parameters, it is time for public policy to reflect it.

It will no doubt be frustrating for policy makers to incorporate this degree of heterogeneity, even if they were to become aware of it. It is so much simpler to accept the sound bite that a sex offender is a sex offender or, as noted earlier, "the simple truth is that juvenile sex offenders turn into adult predators." But making intelligent policy requires that the facts about diversity be considered. Sadly, the worst way to reflect diversity in policy—using charged offense or age criteria to create broad categories—is probably the most commonly employed. For example, the Adam Walsh Act sets a maximum age of 14 at which states must begin submitting juveniles with certain charged offenses to the national public sex offender registry. To be in compliance, states may choose to be more inclusive (but not less inclusive) and include youth younger than 14 or broader offense categories. Some states already do, so the Adam Walsh Act provisions ultimately may apply to broader and younger groups.

The Adam Walsh Act definition includes, at a minimum, any youth age 14 or older whose sex offense is against a child under 12. The Justice Department official in charge of implementing the AWA defended this criterion as "teens who committed incredibly horrific sex crimes" (Rogers, quoted in Michels, 2007). But again, this claim is in contrast to the actual facts. Having an under-12 victim says virtually nothing unusual about a 14-year-old in trouble for sexual behavior. In fact, age 14 is the *peak* age for committing sex crimes against children under 12—it is the most common age at which individuals engage in illegal sexual behavior against children under 12. Juvenile-on-juvenile behavior accounts for about half of all under-12 sex crime victims, and the average

age difference in these crimes is about 4 years. Consistent with this, the average victim age for 14-year-old offenders is about age 10 (Ormrod, Finkelhor, & Chaffin, in press). The behaviors involved in these common juvenile-on-juvenile scenarios are quite broad, from touching over the clothes to forced intercourse. Motivations and victim impact are also broad. The Adam Walsh Act definition will sweep up a large and not particularly selective group of youth in their middle teenage years, including a substantial number of situations that would not be characterized as “incredibly horrific” by even the staunchest victim advocate. This is because the definition and victim age cut-off was drawn directly from federal sex crime statutes designed for adults (where victimizing children under age 12 is more appropriately considered aggravated and potentially reflecting a paraphilia). The AWA applied the adult sex crime classification system to juveniles with no accommodation for the developmental differences between an adult and a 14-year-old and no apparent appreciation for the epidemiology and diversity of juvenile-on-juvenile sex crimes. Ultimately, attempts to divine juvenile sex offender risk status or management needs according to criteria such as legal classification or charged offense are doomed to fail. The population is too diverse and the criminal justice administrative categories are too crude and to a certain extent too arbitrary.

As we might expect for such a diverse population, efforts to identify risk on an *individual* basis have yielded far more promising results than efforts to capture risk via broad administrative categorization. Individually focused actuarial risk assessment has been the main success story in the adult sex offender field during the past two decades, and now we are seeing similar progress made among adolescents. A number of objective individual factors predict risk. For example, having completed any sort of credible treatment program conveys a substantially lower risk than failing to complete. So do a number of stable background characteristics and fluid lifestyle elements. Individual risk factors have been grouped into risk prediction tools (such as the JSOAP-II; Righthand et al., 2005), and initial testing suggests that these tools can improve risk prediction. Interestingly, in light of the discussion on specialness, it appears that the “generalist” dimensions of these tools (i.e., those tapping general delinquent or antisocial proclivity or environmental instability) are more significant predictors than the “specialist” items focused on sexual deviancy (Parks & Bard, 2006). Moreover, the studies demonstrate that risk is not fixed and permanent. Risk changes in accordance

with family and environmental stability, treatment completion, and other dynamic factors (Martinez, Flores, & Rosenfeld, 2007; Prentky et al., 2002). As life circumstances change and as time passes, risk can drop significantly. There are no comparable risk assessment tools for preteen children with sexual behavior problems. Frankly, after enrolling in credible treatment, the long-term risk for preteen children is so low that little additional risk assessment may be required, except in dramatically self-evident cases.

How would risk and service need consideration that is individual and dynamic, as opposed to categorical and fixed, translate into better public policy? It would mean more up-front and careful individual case assessment work, to be certain, but it would also mean that many of our specialized monitoring, treatment, and management resources would be freed up to concentrate efforts on the far smaller number of genuinely high-risk cases rather than the far larger number of cases where current policies are onerous. It would also mean far more individualized services plans. Individualized and dynamic consideration of risk and service need also would imply considering how young people’s risks and needs change over time, rather than treating youth as though they have mutated into permanent members of a special species. Young people’s risks and needs at age 14 are unlikely to be their risks and needs after even 1 or 2 years.

But there are obstacles to the individual approach as well, both procedural and due to the level of quality control that individual risk and needs assessment would properly demand. Currently, we might question whether fair and reliable individual juvenile sex offense risk assessments could be expected, although achieving this is not outside our grasp. The technology is improving year by year. But like the policy field, the clinical practice and juvenile justice fields are permeated by urban myths, adult sexual deviancy-based assumptions and misperceptions about these youth. Reeducation would be needed to prevent evaluators and decision makers from reflexively labeling virtually every individual youth with a sex offense as high-risk, or as needing sexual deviancy treatment, in effect replicating the current misguided policies.

MISPERCEIVED INTRANSIGENCE

The final theme contradicted by the available facts is a related one—the perception that youthful sexual behavior problems and sexually abusive behavior are tenacious and difficult to change and require not just specialized intervention but lots of

it. Again, this is a perception arguably borrowed from the adult sex offender field and applied whole cloth to broad populations of children and teens. The misperception is that juvenile sexual behavior problems are so difficult to change that the intervention should be *high dose*, should be delivered over a *long* period of time; and should involve *more intensive, restrictive, and expensive* elements than for other types of juvenile behavior problems. The facts suggest that these perceptions are often false. In fact, treatment research has yet to locate the lower boundary at which treatment dose becomes insufficient for most of these juveniles. As a general rule, juvenile treatment outcome studies report a fairly narrow range of outcomes across treatments of different formats, approaches, doses, settings, intensities, and durations (Caldwell, 2002). There is no scientific justification for the unfortunately common practice of requiring years and years of juvenile sex offender treatment—a practice that is likely unnecessary in all but a few cases, and might potentially even prove harmful in others.

With one exception, all of the preteen treatments described in the research literature have been short-term (St. Amand et al., 2008), although treatments in field practice are not. Carpentier et al. (2005) found that a 12-session outpatient protocol yielded outcomes meeting a functional criteria for “cure.” It is unlikely that adding doses beyond 12 sessions would improve much on cure. Changing childhood sexual behavior problems for the long haul does not appear to require complex treatment, long-term treatment, or in-depth treatment as a general rule. In fact, wait-list studies of preteen children have shown that childhood sexual behavior problems improve naturally with *no* treatment, although treatment accelerates this improvement (Silovsky, Niec, Bard, & Hecht, 2007), and treatment type does appear to matter for achieving long-term success. Moreover, rapid responsivity is not limited to the easier child cases. The children enrolled in many of these studies included the kinds of serious sexual behavior problems and comorbidities commonly misperceived as indicating intransigence. In studies that have separated children by severity, it was the highest symptom groups that showed the most rapid improvement (Silovsky et al., 2007). Given that good response is generally found using fairly limited and low-burden treatments (especially those that include evidence-based elements), there is little foundation to policies or practices dictating long-term treatment or placing these children into residential treatment facilities on more than an occasional basis (Chaffin et al., 2006). Yet this is common in many jurisdictions,

where children or teens with sexual behavior problems are automatically earmarked for highly burdensome, restrictive, and lengthy treatments often delivered in institutional or out-of-home settings.

The available facts also are inconsistent with the therapeutic ideologies sometimes espoused in these types of long-term or residential settings, which hold that sexual behavior problems reflect deep-seated pathological schemata that must be surfaced, processed, worked through, and reintegrated before lasting change can be seen. It does not appear that a total personality overhaul is required. Clinical perceptions that these behaviors are quite difficult to change may say more about the service model being used than about the child’s actual intransigence.

Although we have long realized the guiding principle of using the least restrictive and least burdensome treatment environment for other juvenile populations, juvenile sex offenders are one of the few remaining populations where long-term institutional care is accepted on a routine basis. This is not to suggest that no child with sexual behavior problems or no adolescent sex offender is appropriate for long-term intensive treatment or residential treatment, but rather that both should be used sparingly, far more sparingly than is currently the case in many jurisdictions. This point particularly applies to the poor practice of shipping children off to sex offender treatment facilities hundreds of miles away from their home. We must be careful to disentangle vested corporate or entrepreneurial interests and poorly supported clinical lore from the real needs of children, including the needs of victim children in the same home, when considering policies surrounding out-of-home placement. Decisions about removal and placement are complex, especially in sibling abuse cases, and newer guidelines recommend individualized case-by-case decision making rather than one-size-fits-all policies (Chaffin et al., 2006).

At a policy level, misperceived intransigence to change has cascading service system implications, because the lengthy, restrictive, and expensive treatments dictated deplete funding and workforce resources dramatically. These are funds and workforce resources that could be used to develop a fuller range of services better matched to the actual needs of the service population. For example, the annual cost to place one child in specialized institutional care can easily be more than the annual cost to fund an entire outpatient program for 50 children. Although the equation is not nearly so simple in practice, it is fundamentally true in theory that for every child we *don’t* institutionalize unnecessarily, we

could develop an entire community program using evidence-based practice elements.

CONCLUSION

Juvenile-on-juvenile sex crimes are a real and prevalent problem requiring serious policy consideration. But it is a policy domain currently fraught with misperceptions. Fortunately, the facts as we know them about children with sexual behavior problems and teen sex offenders paint a far more optimistic picture than popular misperceptions would suggest. Given some sort of credible intervention, long-term risk is generally low and not unusually different from that of many other common and far larger juvenile groups. Recidivism hazard rates decline quickly, suggesting that we do not need to take a long-term risk focus with the vast majority of these youth. Risk often can be managed by teaching caregivers basic parenting and monitoring skills and does not require a complete mental health overhaul. For the overwhelming majority of youth, the problem is in no way commensurate with the stereotypic image of pedophilic adult child molesters or sexual predators, let alone child sex murderers. Evidence-based models and practice elements that work for other juvenile behavior problems tend to work for many of these youth as well. Subspecialty expertise or esoteric treatments are not invariably needed in order to be effective. We are not dealing with a special sexually mutant category of human being, but rather with youth who are incredibly diverse in almost every respect. When we deliver fairly straightforward, practical, and low-burden services that include common evidence-based elements, the problem tends to change promptly and the benefits are durable in the long run. We can and probably should refocus our child protection and management concerns on a very small number of higher risk individuals, and reconsider these risk determinations at fairly close intervals because they are likely to go down. We have rapidly improving technology to assist in making objective and reliable individual risk discriminations.

But good news is not always welcome news. Vested political or financial interests and highly emotional advocacy agendas will complicate healthy skepticism about the facts or their dispassionate consideration. Moral panic, righteous indignation, and truthiness have their own allure and satisfaction. The sound bite that we should put our kids' safety before the rights of sexual offenders, adult or juvenile, sounds so intuitively correct that it is a guaranteed political winner, even if the policy it promotes is ultimately destructive and fails to deliver the child protection goods. It has taken

two decades to disseminate and institutionalize our current misperceptions and enshrined them in everything from the juvenile provisions of the Adam Walsh Act, to state and local placement policies, to local treatment standards, to clinical lore. It may take an equivalent period of time before the policy process can digest a different, but better founded, set of facts. It will be important for child abuse professionals and child protection advocates, not just the juvenile sex offender treatment field, to join the educational effort. Who better than child protection advocates to champion that we should not harm our youth in the name of well-intentioned but weakly founded efforts to protect them?

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