

RESIDENTIAL TREATMENT PROGRAMS FOR JUVENILE SEX OFFENDERS: DEINSTITUTIONALIZATION PROCESS AND TREATMENT MANAGEMENT CONCERNS

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ABSTRACT

Residential treatment for Adolescent Sexual Offenders has often been regarded as a last resort due to popular belief that their treatment should be least restrictive like in an out-patient environment. For these believers Residential Treatment Programs (RTPs) are not *true* representation of deinstitutionalization because such programs do not provide a considerable degree of freedom as in a home environment, where the adolescent can do whatever he/she can whenever he/she wants with whoever he/she will associate. While such an ideology is an admirable to some extent, the real issue is whether the deinstitutionalized adolescent is properly equipped to exercise such freedom responsibly in a way that his/her risk to self and his/her community is minimized. In reality, it is more than just a physical placement or part-time supervision of children. Their treatment, especially in case of sexual offenders, requires re-socialization and preparation for re-entry into mainstream community setting. While such an emphasis on close supervision and preparation of youth through re-socialization, and treatment justify RTPs, it is often difficult to determine the scope and standards of RTP, owing to the lack of consistent guidelines for the assessment of degree of pathology or mental illness among children and adolescents. Despite some basic consensus, treatment placement is frequently decided by various assessment methods adopted by clinicians, each of which is preferred based on their own perspective and/or disciplinary analysis of the client's psychological vulnerabilities as well as client's risk to the community. In general, children in residential treatment are believed to be not significantly different from those placed in less intensive settings; nonetheless, they lack the structure that prepares them to make good choices for them and for their communities. Specifically, the lives of children in RTPs are often characterized by difficulties with strained family relationships at interpersonal level; and, behavioral, emotional, and psychological issues at intrapersonal level. Additionally, youth tend to have a history of substance abuse, family violence, mental illness, and criminal activity resulting in out-of-home placement. In other words, the adolescent sexual offenders are also less likely to have supportive networks than other youth offenders, which results in their inability to gain control over their poor psychological and emotional health a major gap that residential treatment programs can and shall fill.

Key words: *Adolescent Sexual Offenders, Residential Treatment, Juvenile Detention, Case Management, Offender Assessment, Residential Admission Criteria*

Residential Treatment Programs and Their Importance

Residential treatment programs (RTPs) are twenty-four hour closely watched facilities designed to address mental health issues among children and adolescents through effective guidance and intervention strategies from multi-disciplinary teams. Residential programs, managed properly with multidisciplinary approach, will significantly improve the overall mental health of children and adolescents (McCamey, 2010). Many treatment effects are long lasting beyond the clients' discharge from the program. While the goal of deinstitutionalization is to use the least restrictive setting, it is evident that community mental health cannot meet specific needs of each client. Hence the need for more intensive levels of treatment, for instance, residential treatment (Hair, 2005). The ultimate motive of RTPs is to empower youth and restore their relationship with families and communities in order to help them grow as responsible citizens.

RTP is a multi-leveled program which involves.

- (i) The effective use of resources to enhance the competence of youth (skill building)
- (ii) Resources to help family become a youth development enhancing system (family empowerment)
- (iii) Rearrangement of traditional institutional practices to permit the surplus population to escape from nonperson status and more fully participate in community programs (institutional renewal and reformation)
- (iv) Attempts to avoid labeling and shift the value system toward the importance of stigma-free human growth (genuine interest in individual development).

In both rhetoric and practice, the formal arrangements for juvenile treatment program are increasingly becoming linked with community resources—schools, families, and neighborhoods (Murty, 1996). In the same vein, RTP can provide a consistent, nurturing environment along with predictable and consistent expectations, which help shape and guide more desirable behaviors that lead to better outcomes and resiliency (Hair, 2005). RTP can generate promising results especially when linkages to community based services are added following discharge. Variables that can affect treatment outcomes include the staff, philosophy, the relationship between the client and therapist, and individual characteristics and family involvement. Residential treatment can be a valuable intervention, but must be followed with some sort of aftercare (Hair, 2005).

Description and Characteristics of Pre-Adolescent and Adolescent Sexual Abusers

Due to children's developmental stage, age and poor rationality (or judgment), classification of their sexually abusive behavior for the purpose of identifying appropriate treatment interventions must be done with caution. Such classification should be guided by empirical findings and treatment interventions must be designed specifically to meet the child's individual treatment needs. For example, children who sexually act out or demonstrate sexually abusive behavior may be classified as "child perpetrators," but better understood as a child who is highly traumatized due to a disorganized family environment and/or exposed to sexual activity and abuse. Another term that experts commonly use in the field of child and preadolescent sexual abuse studies is

“sexually aggressive child” (Johnson, 1991; Araji, 1997). These terms denote seriousness of the sexually abusive behavior displayed by young children.

Some studies suggest that children begin to sexually act out as early as when they are six years old and begin a pattern of sexually maladaptive behaviors that become deviant and aggressive in nature as the child moves into adolescence without appropriate treatment interventions (Araji's, 1997; Division of Children, Youth, & Family Services, 1987; Johnson, 1991). Others suggest that children may sexually act out even when they are younger (3 or 4 years) by displaying sexual reactive behaviors toward peers—that involves touching, fondling and humping their peers. This behavior is often a reaction to the child's own history of being sexually abused (Araji, 1997; Johnson, 1991). Children who sexually abuse other children are more likely to have experienced severe sexual abuse involving genital contact and penetration (Friedrick and Luecke, 2000).

Classification of Sexually Abusive Children

Johnson (1991) developed an evaluative tool to divide sexually abuse behaviors of children into four distinct categories for explanation: 1) normal sexual exploration; 2) sexually reactive; 3) extensive mutual sexual behaviors; and, 4) child perpetrators. The underlying factors of distinction among these categories are the nature and manner of the child's sexual abusive behavior. For example, normal sexual exploration is described as voluntary sexual play that involves same age peers in a non-threatening or coercive manner. Sexually reactive children are described as sexualized children who are most likely sexually abused, exposed to pornography or products of a highly sexualize family or home setting. These children tend to expose themselves to others, touch their peers genitals or possibly of adults but feel some degree of shame about their behaviors.

Children who are described as having extensive mutual sexual behaviors actively participate in sexual behaviors with consent of others through oral, anal and vaginal intercourse. They do not appear to demonstrate remorse or guilt for their fixation and preoccupation with sexual activity and have little desire to stop their behavior. Prior research indicates that most of these children have been sexually abused and engage in sexual activity as a way of coping with their feeling and emotions associated with their own history of sexual victimization. Finally, a child perpetrator is the one who engages in sexual abusive behaviors through impulsive, compulsive and aggressive acts through coercion. Children in this group generally associate sex with anger and aggression.

Johnson (1991) further notes that child sexual offenders may also associate sex with feelings of fear, loneliness and abandonment and are more likely than other groups to have been exposed to sexual violence, hard core pornography and sexualized relationships. Additionally, Araji (1997) created a fifth group, "sexually aggressive children," who are at the extreme end of a childhood sexual behavior continuum. Similar in offending patterns to Johnson's fourth group of "child perpetrators," Araji finds them to be different in that they seek power and control as their behaviors increase in frequency over time. They are also most resistant to treatment intervention.

Classification of Sexually Abusive Juveniles

Hunter et al. (2003) observed that juveniles who sexually abuse children differ from those who offend their female peers. Juveniles who offend children have more deficits in psychosocial functioning, are less aggressive, likely to have a relationship with their victim, and less likely to be under the influence of a substance. They are also likely to suffer from lack of social confidence, depression, anxiety and pessimism (Hunter et al., 2003).

Families of all types of juvenile offenders have less positive communication, less warmth, and more parental violence. Besides, sexual offenders are more likely to experience a higher level of academic problems than other juvenile delinquents. Juvenile sexual offenders in general experience social isolation, low bonding, popularity, and association with deviant peers. Adolescents who abuse much younger children are more likely to be immature compared to their peers (Letourneau and Milner, 2005).

Juvenile sex offenders may have certain individual characteristics that may predispose them to sexual offending. Psychopathology may be an underlying risk factor of influencing sexual misconduct (Egan et al. 2005). Research in this area is scanty and additional research is needed to further our understanding, examining, or analyzing the characteristics and risk factors for juvenile sex offenders.

In sum, child sex offenders may themselves have been mistreated throughout their childhood and into adulthood. Juveniles who were mistreated are more likely to have a higher rate of sexual offenses than those never were abused. Other common risks for becoming a sex offender could be attributed to family violence, low socioeconomic status, family criminality, and sexual abuse (Pithers & Gray, 1998, 2008). Further research should address personality characteristics of juvenile sex offenders. Additional research is needed to understand the differences between juvenile sex offenders and the rest of their peers (Freeman, Dexter-Mazza, & Hoffman, 2005).

Treatment Strategies and Services

The area of treatment of juvenile sex offenders received a growing attention since late 1980s, which resulted in increasing number of available treatment programs and evaluation of their efficacy. Ertl & McNamara (1997) underscores the importance of making the decision of residential versus outpatient treatment for treating juvenile sex offenders. Residential settings, in particular, must meet the clients' needs based on their case histories, contrary to the notion of some that other juvenile offenders and juvenile sex offenders can be placed together for group work. Also, consideration needs to be given if treatment options should vary based on the type of juvenile sex offenders.

The first step in treatment development plan is determination of goals. Several treatment approaches are available for adolescent sex offenders. First, the strategy of confronting denial, accepting responsibility, and generating victim empathy— not only prepares the clients in acknowledging that their actions were not only wrong, but also provide them with the opportunity of viewing themselves through the eyes of their victims. Specific offense targets include denial and minimization; victim harm and victim empathy; offense-supportive attitudes, beliefs and distorted perceptions; offense fantasies; and relapse prevention. Denial and

minimization involves the offender attempting to shift the blame or deny their crime. Programs will attempt to help sex offenders to admit responsibility and some programs will even deny admittance based upon offenders' denial and minimization. Victim harm and victim empathy attempts to aid the offender in understanding what happened through the victims' eyes. Attitudes, beliefs, and distorted perceptions deal with the unrealistic viewpoints that an offender has toward women and children (Marshall, 1996).

Second, the method of cognitive restructuring focuses on beliefs and distortions that allow the offending to occur. A key component with this intervention requires juveniles to admit and verbalize their thoughts used to justify their behavior. That way the therapist or (if in a group) other group members can challenge these maladaptive thoughts. Another component of cognitive restructuring involves role playing. Due to misinformation of many juvenile sex offenders, sex education becomes another component within cognitive restructuring (Ertl & McNamara, 1997).

Third, the technique of decreasing deviant sexual arousal that requires a change in sexual arousal patterns through cognitive-behavior therapy and medication. Satiation training is yet another approach, which "involves instructing an offender masturbate to ejaculation while thinking about or watching a scene of non-deviant sexual content and continuing to masturbate post-ejaculation while thinking about or watching a scene involving deviant sexual content. However, the use of satiation training with juveniles appears to question the ethics of such approach with this particular population. Another option would be verbal satiation in which the offender uses words to satiate themselves instead of the deviant patterns that used to satiate the offender (Ertl & McNamara, 1997). This approach may work better for juveniles, but the problem of determining the perpetrator's thoughts cannot ever be examined except through the use of self-reports.

Covert sensitization is another technique used in treatment programs. Covert sensitization requires the offender to imagine the feelings prior to the actual offense and then is introduced to negative and aversive consequences in result of a sexual offense. However, again this technique brings up ethical concerns when utilized with juveniles. Systematic desensitization involves the imagining desensitization leading up to the offense. Psychopharmacological treatment involves the use of antiandrogenic drugs. This approach has been found to decrease deviant sexual arousal in adults (Ertl & McNamara, 1997). However, the effectiveness of using such treatment therapy with adolescents is yet to be determined. Further research must involve understanding the usefulness of these treatment approaches utilized with adolescent sex offenders.

Adjunctive treatments for juvenile sex offenders include social skills training, anger control training, substance abuse, and dealing with victimization and abuse (Ertl & McNamara, 1997). Future research should examine the effectiveness of these adjunctive treatments due to lack of empirical data. Relapse prevention is yet another way to help juvenile sex offenders. Relapse prevention involves teaching offenders how to cope with situations that may influence them to commit inappropriate sexual acts. However, no research has clearly analyzed whether relapse prevention actually prevents juveniles from recidivism (Ertl & McNamara, 1997).

Treatment Modalities

Treatment modalities include group therapy, individual psychotherapy, family therapy, and multisystemic therapy. Group therapy provides the opportunity for peers to learn from each other and model more appropriate behavior. Sole reliance on individual psychotherapy does not seem to be highly effective when working with juveniles. Therefore, it should be used in conjunction with other modes. Family therapy allows the adolescents to deal with any problems or difficulties within their family system that may have attributed to their sexual offending (Ertl & McNamara, 1997). Multisystemic therapy, a broad therapy model, incorporates multiple environment characteristics in order to intervene on the behavior. While each of these modalities have their own merits, more systematic assessment of treatment programs is needed in order to provide the best models of treatment for adolescent sex offenders (Vizard, Monck, & Misch, 1995). Future research should also attempt to study adolescents on long-term basis in order to determine the effectiveness of treatment and associated chance of recidivism (Langstrom, & Grann, 2000). Researchers should undertake cohort studies that allow to follow specific adolescent offender groups throughout their lifespan in order to get a clear picture on recidivism rates. However, such studies are subject to high attrition rates because of difficulty in following up. Mere focusing on criminal records is inadequate in recidivism research. The dearth of evaluative research creates a wide gap in the effectiveness of treatment programs, thereby hinders the goal of preventing future sexual misconduct.

Beliefs and Barriers

There are some common beliefs held about juvenile sex offenders. One belief is that without treatment, there will be an increased chance of future offenses. Another belief held refers to sexual offending as a reaction to previous abuse, though not all will become sex offenders. Yet other beliefs refer to sex offenders confusing the sexual act as intimacy. These beliefs all contribute to the current treatment and labeling of sex offenders, all of which needs to be supported by empirical findings (Cashwell, & Caruso, 1997).

There are several barriers considered when working with adolescents who are not only sexually active, but who sexually offend. One barrier would be accepting that these children are becoming sexual beings. Another barrier could be the parent, who may interfere in the process due to his or her own guilt and feelings of responsibility. A last barrier to consider would be the differences of treatment between victims and offenders (Cashwell & Caruso, 1997). If sex offenders have been victims themselves, then treatment for their sex offending should take into account their early abuse. Neglect of this element could have detrimental effects on adequately providing treatment and decreasing the risk of recidivism.

Treatment Process

The first step in intervention with sex offenders would be to determine whether their sexual behavior is age-appropriate or maladaptive. Cashwell & Caruso (1997) offer some guidance in fully assessing the appropriateness of behavior. For one thing, it is important to analyze the knowledge of healthy sexual behavior and sexual abusive behaviors for both the adolescent and their family. It is necessary to establish communication styles and the cohesiveness of the family unit. The degree of impulse control, the level of social skills, and the presence of psychiatric

disorders— all needs to be examined in providing a full assessment of the adolescent sex offenders.

Individual treatment techniques incorporate many ideas such as the client must stop denying and accept responsibility for their actions through the use of confrontation. The juveniles must understand and begin to empathize with the victim, which helps to decrease the rate of recidivism. Treatment should attempt to understand the motives behind the offense; take clients' personal victimization into consideration; focus on educating healthy sexual behavior; and, attempt to change deviant sexual patterns. In other words, cognitive restructuring should be utilized in therapy in order to confront their distortions on sexual behavior (Cashwell & Caruso, 1997).

Group therapy should aim to increase interpersonal skills and support as a way of minimizing isolation and providing confrontation from their peers (Cashwell & Caruso, 1997). Likewise, family intervention should be centered around age appropriate involvement, isolation and anonymity, family stress, intergenerational abuse, healthy communication, and emotional needs. Such a multidimensional approach to therapy affords juvenile sex offenders required support, personality development, empathy, self-control, and better coping techniques.

Although empathy is often considered to be a unique individual characteristic, a clear link between empathy and re-offending is not empirically established because of the complexities involved in operationally defining empathy and measuring it (Lindsey et al., 2001). Lack of empathy on the part juvenile sex offenders is attributed to variations in socialization and strength of their situation; i.e., how intensely one reacts emotionally to the situation. Offenders may have empathy, but in an offending situation, are overwhelmed emotionally and can no longer think of the victim; or, view their victims' emotions differently from their own. Lindsey et al. (2001) used comparison groups and a multidimensional measure of empathy in their study and found that delinquent groups only differed significantly from the non-delinquent group on personal distress scale; and, that non-sex offending juveniles scored significantly higher on personal victimization, individual safety, and self-efficacy scales than juvenile sex offenders. Accordingly, the study concluded that delinquents may have a higher tendency to become emotive during stressful situations than non-delinquents; which in turn, may lead to feelings of powerlessness; then into fantasies of power; and, eventually to offending behavior (Lindsey et al., 2001).

Borduin and Henggeler (1990) studied the efficacy of multi-systemic therapy (MST) in comparison to that of individual therapy among a small group of offenders over a period of 37 months. They found significantly lower recidivism rates (12.5%) among those exposed to MST than those in individual therapy (75.0%). Cognitive-behavioral group therapies are commonly used for adult offenders for the purposes of confronting their denial and exploring the presence of any developmental antecedents in symptom formation. Other therapeutic goals include victim empathy, anger management, and social skills. Behavioral therapies (i.e., aversion therapy, masturbatory satiation) have also been employed for adult offenders. Based on the assumption that sex offending is a form of addictive behavior, some therapies are modeled after the popular 12-step programs for alcohol and substance abuse addictions, with an added focus on relapse prevention.

Pharmacotherapy of adolescents is considered for those who do not respond to other forms of treatment. However, the consequences of mislabeling a juvenile as paraphilic or pathological sex offender are evident in clients' avoidance and higher dropouts from the treatment. Pharmacotherapy, though proven valuable in the treatment of the paraphilias in adults, its efficacy is limited in adolescents. Antiandrogens or the hormonal agents are generally not considered first-line treatments for juveniles with paraphilias, but rather should be reserved for those who do not respond to other treatments. Even in this group, however, pharmacotherapy should not be the sole intervention but should be combined with other interventions; e.g., family therapy, individual psychotherapy, group psychotherapy, social skills training, academic or vocational education, etc. (Aalsma and Lapsley, 2001; Galli, Raute, McConville, and McElroy, 1998).

The Assessment and Admission Process

Assessing sex offenders provides information on the best treatment methods and their risk of recidivism. One type of assessment method includes phallometry, which measures a person's "erectile responses while he watches or listens to various sexual stimuli chosen to represent those categories of behavior thought to be relevant to his offense" (Marshall, 1996, 163). Phallometry is useful for detecting deviant preferences for children among child molesters who offend outside their families. Another type of assessment involves the sexual preference hypothesis; that is, sex offenders commit their deviant sexual acts because of their preference for abnormal sex (Marshall, 1996).

Using either of these assessment methods with juveniles portrays an ethical dilemma. While there has been little support that such methods work with children, exposing adolescents to sexual stimuli poses a difficult situation because the sexual stimuli may encourage further deviant sexual behavior among juveniles (Marshall, 1996). Moreover, studies differ in term of validity and reliability of phallometry because many offenders could use faking strategies, including men portraying a false profile without any sign of actual thoughts or feelings (Marshall, 1996).

Analyzing offender sexual histories provides insight on underlying causes or even indirect influences on maladaptive behavior. Deviant sexual behavior may result from learning or conditioning within one's social and cultural milieu, which can be explored by carefully gleaning sexual histories along with patterns of offending and sequence of progression of offending behaviors. For some sex offenders, culpability stems from their inability to establish intimate relationships with people of a similar age, and sexual fantasies (Daleiden et al. 1998).

Other valuable information in offender sexual histories may contain history of mental illness, behavioral disorders, and sexual misconduct. Understanding any previous trauma, such as physical, emotional, or sexual abuse while in childhood may play a role in the development of future sexual misconduct. Offenders' family issues may eventually show up in the adolescent. Therefore, it is also important to explore the sex offenders' family history (Zussman, 1989, 31).

Utilization of forensic details in assessing adolescent sex offenders is detailed in the work of Zussman (1989). Zussman (1989) also suggests that a comparison of the developmental level at the time of sexual offense and chronological age, while assessing family and support system is

important. Sometimes, an invaluable piece of information about the offense can be traced from the referral source. Examiners must develop an ecological assessment that portrays offenses in various settings and assesses social support, stress, and conflict. There are four main parts to assessing sexual functioning. The first part of the assessment consists of considering the appropriate age behavior. The second part of the assessment analyzes the choice of sexual objects in terms of age and gender. The third part of the assessment looks at the degree of force or coercion. The last part of the assessment determines if a sexual impulse disorder is present (Zussman, 1989).

Psychological testing could be used to indirectly assess adolescent sex offenders' cognitive distortions; and, penile plethysmography for determining adolescents' sexual arousal. However, there are some ethical concerns using such measurements on young men. Therefore, use of psychological testing to assess the intelligence, personality and behavioral characteristics of the adolescent sex offenders is suggested (Zussman, 1989).

Case Management Approaches for Juvenile Sex Offenders

Case management of juvenile sexual offenders differs from that of non-sexual offenders. Some sex offenders are subjected to incarceration, but many are directed to community programs for treatment and prevention of committing future sex crimes. Although some commonalities exist in the overall approaches to managing adult and juvenile sex offender groups, each group requires specific treatment considerations.

An interdisciplinary management of sexual offenders in the community involves utilization of a Comprehensive Approach or a Containment Approach to sex offender treatment. An online training curriculum by the Center for Sex Offender Management [CSOM] details a Comprehensive Approach to the treatment of juvenile sex offenders in terms of assessment process, specialized treatment approaches, supervision strategies, community reentry considerations, and ongoing evaluation.

Parallel to the above approach, English, Pullen, and Jones (1997) present a five-part Containment Approach model, with the following components: an overall philosophy and goal of community and victim safety, individualized sex offender-specific containment strategies, interagency and interdisciplinary collaboration, consistent public policies, and quality control. The containment strategies consist of a three-pronged approach that includes treatment or therapy, official supervision and monitoring, and polygraph examinations.

Though different, the Comprehensive Approach and the Containment Approach are not mutually exclusive, and the two approaches could be used together to treat both juveniles and adults. Both approaches suggest that the primary goals of treatment should be preventing further victimization, promoting public safety, and assisting clients with leading productive, crime-free lives. Both approaches also stress the importance of multi-agency collaboration for treatment to be effective.

Preparation for reentry into mainstream community follows completion of residential treatment, or sentence of sexual offenders. A comprehensive reentry and aftercare plan takes into account the offenders' specialized treatment needs, mental health problems, mental functioning,

healthcare concerns, family issues, independent living skills, educational or vocational needs, community supervision strategies, and community hostility concerns. For those who have committed sexual crimes against family members, it may be necessary to implement a family reunification plan. Ultimately, victim safety and community safety should be paramount considerations in the process of community reentry of sexual offenders. Successful reunification plans are gradual and deliberate, with supervised transitional steps, and are flexible and responsive to the needs of the victims, the family, and the community.

Conclusions

In summary, the current state of our knowledge about juveniles who commit sex crimes is deficient in many respects. Research into the nature, etiology, and treatment of adolescent offending is substantially limited. Like other areas of child and adolescent psychiatry, much knowledge about this group has been determined from data on adults. Compared with adults, juvenile offenders are much more heterogeneous, have higher rates of multiple illnesses, and include many youngsters for whom sexual deviancy is a temporary departure from what is normal or desirable. However, among youthful offenders are those who are on a dangerous course to adult criminal behavior. Therefore, accurate assessment is challenging, but it is essential if we are to deal with juvenile sex offenders in an appropriate manner. It is crucial to remember there are no absolutes or “magic bullets” in the process of identifying risk factors of adolescent offenders. Some sex offenders will inevitably commit subsequent sex offenses, in spite of our best efforts at identification aimed at minimizing these conditions. The challenge to adolescent psychiatry is to diagnose accurately and comprehensively, provide appropriate and comprehensive treatment, and expand the knowledge base with respect to this challenging population. In recent years, treatment protocols for juvenile sex offenders have evolved as professionals recognized that juveniles are not simply younger, smaller adults and thus they have their own set of treatment needs. Both the adult sex offenders and juvenile sex offenders are diverse and heterogeneous populations, with no “typical” offender of either type (CSOM, 2010). This is not to suggest that there are not some significant commonalities among sexual offenders and between the two groups. The harm caused by their sexually abusive behaviors may be just as severe in victims of juveniles as victims of adults. Both groups are more likely to target persons known to them than to target strangers. Both adults and juveniles tend to engage in some degree of fantasizing, planning, or grooming before they offend. Both groups exhibit distorted thinking patterns that allow them to engage in the deviant behavior, giving themselves permission to commit the offenses even though they are generally aware the behavior is wrong or harmful. Correcting these cognitive distortions to prevent relapse is the goal of cognitive behavioral therapy. Both juvenile and adult sex offenders tend to have some form of problems with coping skills or social competency deficits (CSOM, 2010).

A multi-disciplinary Comprehensive Approach to managing sex offenders is an effective means of treating both juvenile sex offenders and adult sex offenders, through a process of assessment, treatment, supervision, reentry into the community, and evaluation. Treatment providers should consider the dynamic and emerging developmental status of juveniles when planning to treat that population of sex offenders, as opposed to treating adult sex offenders. Multisystemic treatment may be an effective option when treating juveniles. Trauma resolution, empathy development, and motivational counseling components may be useful adjuncts to the standard treatment modality of cognitive behavioral group therapy.

Relapse prevention and development of self control as well as psychopharmacological interventions are being finalized as key elements of stabilizing clients' sexual aggression. Involving the child psychiatrist during each step of the treatment process is essential for client's mental and psychiatric health. The Psychiatrist should review client's medication regimen, physical health, blood count, and response to prescribed medication a minimum of once a month, preferably bi-weekly for client's who are experience behavior and emotional difficulties instability while in residential group treatment setting. Life skills advocates have to communicate with administrators, and campus nurse to report client's progress and client's reactions to medication. This collaborative effort strengthens the treatment process and allows for continuation of and integration of treatment strategies designed for the adolescent offender.

References

- Araji, S. (1997). *Sexually Aggressive Children: Coming To Understand Them*. Thousand Oaks, CA: Sage.
- Araji, S. (2001). *Juveniles Who has Sexually Offended: A Review of the Professional Literature*. Washington, D.C.: Office of Juvenile Justice and Delinquency Prevention.
- Borduin, C.M., Henggeler, S.W., Blaske, D.M., & Stein, R.J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, 34(2), 105-113.
- Cashwell, C. S., & Caruso, M. E. (1997). Adolescent sex offenders: Identification and intervention strategies. *Journal of Mental Health Counseling*, 19(4), 336-349.
- Calley, N.G. (2007, Spring). Integrating theory and research: The development of a research-based treatment program for juvenile male sex offenders. *Journal of Counseling & Development*, 85, 131-142.
- Calley, N.G. (2007, April). Promoting an outcomes-based treatment milieu for juvenile sexual offenders: A guided approach to assessment. *Journal of Mental Health Counseling*, 29(2), 121-143.
- Calley, N.G., & Gerber, S. (2008, April). Empathy-promoting counseling strategies for juvenile sex offenders: A developmental approach. *Journal of Addictions & Offender Counseling*, 28, 68-85.
- Center for Sex Offender Management. (n.d.). *The effective management of juvenile sex offenders in the community: A training curriculum*. Retrieved July 1, 2010, from <http://www.csom.org/train/juvenile/>
- Comprehensive Approach to Sex Offender Management (CSOM-2010) *Advancing Sexual Offender Management Efforts Through State Level Policy Groups*. Retrieved July 1, 2010, from http://www.csom.org/pubs/comp_approach_brief.pdf
- Division of Children, Youth, & Family Services. (1987). *Family centered case management with sexually aggressive youth*. Seattle, WA: Washington State Department of Social & Health Services.
- Daleiden, E. L., Kaufman, K. L., Hilliker, D. R., & O'Neil, J. N. (1998). The sexual histories and fantasies of youthful males: A comparison of sexual offending, nonsexual offending and non-offending groups. *Sexual Abuse: A Journal of Research and Treatment*, 10(3), 195-209.
- Egan, V., Kavanagh, B., & Blair, M. (2005). Sexual offenders against children: The influence of personality and obsessionality on cognitive distortions. *Sexual Abuse: A Journal of Research and Treatment*, 17(3), 223-240.

- Epps, K.J. (1994). Managing sexually abusive adolescents in residential settings: A strategy for risk assessment. *Issues in Criminological and Legal Psychology* 21:54-60.
- Ertl, M. A., & McNamara, J. R. (1997). Treatment of juvenile sex offenders: A review of the literature. *Child and Adolescent Social Work Journal*, 14(3), 199-2.
- Frensch, K. M., & Cameron, G. (2002). Treatment of choice or a last resort: A review of residential mental health placements for children and youth. *Child and Youth Care Forum*, 31(5), 307-339.
- Friedrich, W.N. (1990). *Psychotherapy of sexually abused children and their families*. New York: W.W. Norton.
- Friedrich, W.N., Beilke, R.L., & Purcell, J. (1989). *The Child Sexual Behavior Inventory: Version 2*. Rochester, MN: Psychology Department, Mayo Clinic.
- Friedrich, W.N., Beilke, R.L., & Urquiza, A.J. (1987). Children from sexually abusive families: A behavioral comparison. *Journal of Interpersonal Violence*, 2, 391-402.
- Friedrich, W.N., Grambsch, P., Broughton, D., Kuiper, J., & Beilke, R.L. (1991). Normative sexual behavior in children. *Pediatrics*, 88, 456-464.
- Friedrich, W.N., & Luecke, W.J. (1988). Young school-age sexually aggressive children. *Professional Psychology: Research and Practice*, 19, 155-164.
- Galli, V.B., Raute, N.J., McConville, B.J., & Mcelroy, S.L. (1998). An Adolescent Male with Multiple Paraphilia's Successfully Treated with Fluoxetine. *Journal of Child and Adolescent Psychopharmacology*, 8, 195-7.
- Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., & Cunningham, P.E. (1998). *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*. New York, NY: Guilford Press.
- Hair, J. M. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993-2003. *Journal of Child and Family Studies*, 14(4), 551-575.
- Hunter, J. A., Figueredo, A. J., Malamuth, N. M., & Becker, J. V. (2003). Juvenile sex offenders: Toward the development of a typology. *Sexual Abuse: A Journal of Research and Treatment*, 15(1), 27-48.
- Hunter, J. A., & Figueredo A. J. (1999). Factors associated with treatment compliance in a population of juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 11(1), 49-67.
- Johnson-Reid, M. (1998). Youth violence and exposure to violence in childhood: An ecological review. *Aggression and Violent Behavior* 3, 159-179.
- Langstrom, N., & Grann, M. (2000). Risk for criminal recidivism among young sex offenders. *Journal of Interpersonal Violence*, 15(8), 855-871.
- Letourneau, E.J., Henggeler, S.W., Borduin, C.M., Schewe, P.A., McCart, M.R., Chapman, J.E., & Saldana, L. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology*, 23(1), 89-102.
- Lindsey, R. E., Carlozzi, A. F., & Eells, G. T. (2001). Differences in the dispositional empathy of juvenile sex offenders, non-sex offending delinquent juveniles, and non-delinquent juveniles. *Journal of Interpersonal Violence*, 16(6), 510-522.
- Marshall, W. L. (1996). Assessment, treatment, and theorizing about sex offenders: Developments during the past twenty years and future directions. *Criminal Justice and Behavior*, 23(1), 162-199.
- McCamey, J (2010). Reducing Recidivism in Adolescent Sexual Offenders by Focusing on Community Reintegration. *Residential Treatment for Children and Youth*, 27:55-67.

- Murty, K. S. (1996). Need and trend towards deinstitutionalization: Recourse to reduce institutionalization and development of alternative non-official social control mechanisms in management of juveniles. *Research Notes: A Monthly Bulletin from the Research Forum*, (Andhra University Press, India), 2(9):1-3.
- Pithers, W. D., & Gray, A. (1998). The other half of the story: Children with sexual behavior problems. *Psychology, Public Policy, and Law*, 4(1/2), 200-217).
- Vizard, E., Monck, E., & Misch, P. (1995). Child and adolescent sex abuse perpetrators: A review of the research literature. *Journal of Child Psychology and Psychiatry*, 36(5), 731-756.
- Zussman, R. (1989). Forensic evaluation of the adolescent sex offender. *Forensic Reports*, 2, 25-45.