



# APSAC ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

## SPECIAL ISSUE ON ADOLESCENT ILLEGAL SEXUAL BEHAVIOR (AISB)

Guest Editor:

Barbara L. Bonner, PhD, University of Oklahoma Health Sciences Center

### **Challenges to Evidence-Informed Practice and Policy Concerning Adolescent Sex Offenders**

Mark Chaffin, PhD

This commentary discusses many of the issues facing practitioners and policy makers when serving youth with AISB. The article describes the complex relationships between scientific evidence, clinical practice, and policy development. It also highlights the dangers of applying findings from research on adult sexual offenders to AISB.

2

### **Adolescents With Illegal Sexual Behavior: Current Knowledge**

Barbara L. Bonner, PhD

This article provides a summary of the current state of knowledge regarding adolescents with illegal sexual behavior. It differentiates AISB from adult offenders, describes strategies for assessment and treatment, and delineates ethical issues in working with this population of youth.

5

### **Typology of AISB: An Update**

Keri Pierce, MPH, MSW

This article describes issues in developing a valid typology of youth with illegal sexual behaviors, and the challenges encountered in attempting to use a typology to inform decisions about treatment and other interventions. The article also reviews several assessment tools that have been researched for use with AISB.

9

### **Adolescent Girls With Illegal Sexual Behavior**

Susan Schmidt, PhD

Most of the research on adolescents with illegal sexual behaviors (AISB) has focused on males. However, increasing numbers of girls have been coming to the attention of the juvenile courts as a result of illegal sexual behaviors. This article summarizes what is known about the characteristics and treatment needs of girls with AISB.

12

### **MST: Treatment for Adolescents With Delinquent Sexual Behavior**

Elizabeth J. Letourneau, PhD

Charles M. Borduin, PhD

Originally developed for treatment of delinquent youth, multisystemic therapy (MST) has been suggested as a promising treatment for youth with AISB, who have more in common with other delinquent youth than is generally assumed. This article reviews recent research on the adaptation of MST for the treatment of youth with illegal sexual behaviors.

14

## REGULAR FEATURES

- Journal Highlights ..... 18
- Washington Update ..... 22
- News of the Organization ..... 25

## ALSO IN THIS ISSUE

- Conference Calendar ..... 27

## Challenges to Evidence-Informed Practice and Policy Concerning Adolescent Sex Offenders

Mark Chaffin, PhD

Any commentary prioritizing current issues is to some extent subjective. There might be different lists depending on the source. Ask a trial lawyer, and the issues may pertain to court proceedings. Ask a therapist, and the issues may pertain to therapy techniques. My own perspective is that of someone concerned with how science can inform practice and public policy.

The science-practice relationship has prompted quite a bit of dialogue in recent years. For example, the rise of the evidence-based practice perspective has been perhaps the decade's defining issue in social and mental health services. Similarly, the potential role that science can play in public policy has been discussed as a timely priority in a recent *APSAC Advisor* issue (Higgins, Chan, & Ponder, 2006). The ascending influence of research evidence in these areas remains contentious, which should be expected considering that practice and social policy have historically been value and ideology driven. Facts historically have been selectively cited to buttress a pre-existing, value-based agenda rather than used broadly to determine what our agenda should be. Some degree of push-back against the increasing role of scientific evidence is probably natural. It is also not unreasonable—few would advocate that science alone should dictate practice or policy decisions.

Where teens who commit sex crimes are concerned, we have seen fairly limited infusion of scientific evidence into either clinical practice or public policy. Indeed, I would argue that this is a practice and policy area that has not readily embraced scientific evidence. This is a dynamic underlying many current controversies. For example, there have been endless debates over use of polygraph interrogations with these youth, a technique many scientists consider pseudoscience but many practitioners and policy makers embrace with steadfast devotion. In this commentary, I will examine obstacles to integrating science into teen sex offender practice and policy.

### Scientific Evidence and Clinical Practice

It is becoming increasingly clear that the fundamental assumptions underlying many current clinical practices with these youth are flatly unsupported for the majority of cases. This applies primarily to the downward developmental translation of adult pedophile-based treatment and management assumptions. These assumptions have translated into a set of clinical practices often, if somewhat imprecisely, labeled as "sex-offender specific therapy." Examples include the use of "cycle" or relapse-prevention techniques (based on the erroneous assumption that youthful sex crimes involve an engrained, stereotypic, compulsive or addictive pattern); reliance on cognitive psychotherapy (based on the doubtful assumption that the problem is more attitudinal than contextual); use of aggressive group therapy techniques (based on the erroneous assumption that peer confrontation is needed to break down denial about hidden deviancy); routine placement in residential facilities (based on the presumed but questionable benefits of massive treatment dose, separation from family and mainstream society, and aggregation with other delinquents); and use of the polygraph (based on the dubious assumption that how much someone sweats during in-

terrogation reveals what they are truly thinking, and the untested assumption that this procedure improves ultimate outcomes). The misperceptions underlying current juvenile sex offender practices—misperceived level of risk, misperceived "specialness," misperceived homogeneity, and misperceived intransigence to change—have been summarized and analyzed in a lengthier paper (Chaffin, in press) for readers who are interested in a fuller analysis of these issues.

Conceptually, the deficiencies of the adult pedophile model applied to youth are not particularly controversial or new (Letourneau & Minor, 2005). In fact, many or perhaps most clinical treatment providers, including many who practice derivatives of adult-model techniques, would probably agree that the adult model adapted downward to teens is a mismatch in most cases. Many would agree that when it comes to practice, something different is needed. The real questions are what that something different might be and how to make the switch. What the something different might be is the easier of the two questions to tackle. It is increasingly clear that multisystemic therapy (MST) not only has better supporting evidence than traditional sex-offender specific treatment but also, according to early findings from a head-to-head randomized trial, that overall outcomes are superior. This might be especially the case where youth have general (i.e., nonsexual) behavior problems and delinquency risks, which is a sizeable concern among teenagers who commit sex crimes. Juvenile-on-juvenile sex crimes are probably similar in many ways to other, nonsexual, juvenile delinquent behaviors, so it is not surprising that what works for the latter will work for the former. Given that MST comprises well-established component elements that are shared in common by many evidence-based delinquency programs (e.g., using focused behavioral techniques, working with and through caregivers rather than in peer group therapy, working to keep teens engaged in school and positive peer activities, increasing caregiver supervision and behavior management skills, and strengthening caregiver-teen relationships and communication), it is quite possible that other evidence-based delinquency programs containing these common elements could also be found to deliver similar advantages compared with traditional sexual deviancy-oriented sex offender group therapy.

The more difficult question is how to get these alternative models and elements adopted and implemented. It is important to consider that the adolescent sex offender treatment system is fairly entrepreneurial in its structure and that it is currently concentrated within small practice and residential treatment facilities. Many community programs for teens who commit sex crimes are housed in individual or small practice offices, which are suited to delivering clinic-based individual or group psychotherapy but may be poorly suited to using MST or related evidence-based models where caseloads are smaller, treatment contacts are less regularly spaced, service durations are shorter, and most service delivery occurs outside of office settings. Moreover, because the adolescent population is diverse, it is likely that emerging best practices will come to dictate very different intervention programs for different

## CHALLENGES TO EVIDENCE-INFORMED PRACTICE AND POLICY

population subgroups. As a result, some of these solutions may be beyond the capacity of small or individual office practices. We may need to consider that some delinquent teens in trouble for sexual behavior could be better served outside of the sex-offender treatment provider world if models such as MST prove too difficult to implement within that world.

Reimbursement issues also pose challenges. Practice in traditional clinical settings is strongly driven by third-party reimbursement contingencies that are notoriously conservative. Such contingencies commonly drive practice in the direction of older (or even obsolete) practice modalities such as office-based individual or group psychotherapy, even when the scientific evidence points toward better and more cost-effective alternatives. Economically, individual or small group practices may depend on long-term clinic-based psychotherapy for their survival and may be inadequately reimbursed for the costs of transitioning to different models. A combination of prohibitive start-up costs and uptake complexities, inertia, competing day-to-day demands, reimbursement contingencies, and emotional ties to old ways of thinking and working may combine to make change unlikely in these settings. Many practitioners would no doubt like to change because they value innovation and because they believe in evidence-based practice, but they find it simply too difficult to make the switch. We need to make it less difficult.

The obstacles to change in residential programs may be even greater. Residential facilities and the corporations that operate them have invested considerable resources and realize substantial income from the practice of placing teens who commit sex crimes in long-term residential treatment to a far greater extent and for far longer times than other youth. The length of stay for these teens is often more than double that of youth placed for other types of serious offenses, and vastly longer than for youth with other serious mental or behavior problems. There is little or no scientific evidence supporting this disparity. This is not to suggest that residential care isn't occasionally necessary but, rather, that current utilization is exaggerated. In this case, making the switch to evidence-informed programming (which would emphasize shorter stays and more community-based care for a substantial portion of the youth currently being placed in long-term care) would not be merely inconvenient or difficult. It would also involve downsizing a large and highly capitalized corporate enterprise that is dependent on established ways of practicing for its cash flow, so we can expect opposition.

Similar challenges to innovation could be observed in any psychosocial practice field. These types of challenges are normally balanced by countervailing market forces, including consumer demand or policy demands. But countervailing market forces may have relatively less influence when it comes to adolescent sex offender practice. Consumer (i.e., patient) demand plays virtually no role in this practice area, and it never really has. In fact, many would take issue with characterizing these teens and their families as the "consumers" at all. Would youth and their families prefer services that were shorter-term, involved lower burden, and delivered greater expected benefit? This is a rhetorical question. These are not voluntary but instead coerced consumers, who often have no choice when it comes to service selection. For example, youth

and families may be compelled to receive a particular undesired service from a particular undesired provider, even when an alternative is available that the scientific data might support as having equal or better effectiveness. The stigma associated with being a "sex offender" may make families reluctant to advocate publicly or to organize. Consequently, we cannot expect consumer forces to push much practice change.

### Scientific Evidence and Policy

Regulations and policy are another force for change, but these may be constrained for a number of reasons. Few things prompt fear and outrage as do sex offenses. The public and policy makers often are uninformed about the vast differences between youth in trouble for sexual behavior and the sorts of horrific adult sexual predator cases publicized in the media. The actual danger posed by these youth is widely overestimated, but it is not high either in absolute terms or relative to other groups of delinquent youth (Caldwell, 2007). Juvenile probation officers, child welfare workers, and treatment providers, along with their respective supervisors and agency heads, may experience acute concern that one of these cases will "go wrong," and result in a frenzy of blaming and finger pointing. Of course, we should never excuse carelessness, negligence, or incompetence in teen sex offender cases or any others. But the fact is that things can go wrong even when case handling is done in the most responsible and competent ways possible. Public agencies and treatment providers are acutely aware of this reality. Part of this reality is that some of the ways in which cases can go wrong are vastly more visible and therefore more politically risky than others. For example, if a youth is retained in the community rather than institutionalized and things go wrong, the error may be highly visible and viewed as negligent. However, if a youth is institutionalized and becomes more delinquent or dangerous due to his institutional experience compared with what he would have been if he had remained in the community, this failure may not be visible, even if it ultimately causes the same or greater downstream harm to community safety. In this case, it might falsely appear that the system acted better safe than sorry, rather than the reality that the system actually made matters worse.

The illusion created by this visibility imbalance can contribute to a mentality favoring restrictiveness (i.e., more GPS monitors, more expulsion from school, more public notification, more polygraphs, longer lock-up, more remand to the adult system) even if the policy direction taken ultimately makes us less safe in addition to being less humane. Iatrogenic risks (i.e., risks caused by the intervention) may be invisible in day-to-day practice but are easily revealed by rigorous scientific studies, which is one reason science is needed in policy decisions. For example, remanding serious delinquents to the adult criminal system is a policy intended to protect the public. A recent meta-analysis by the CDC revealed that policies for remanding juveniles to the adult criminal justice system probably do more harm than good when it comes to protecting communities from crime (Hahn et al., 2007). It appears that these policies actually increase future crime. Unless we have good scientific data, the public and policy makers may remain unaware of these less visible risks.

Cont'd on page 4

## CHALLENGES TO EVIDENCE-INFORMED PRACTICE AND POLICY

Given the current media and political environment, there are real risks associated with change and innovation. Policy makers may opt for practices that limit political exposure by sticking with conventional methods. Innovation may be seen as risky politically, even if it actually improves community safety. When a case goes wrong, security may lie in the conventional and restrictive, even where it is proven to be iatrogenic, and political risk may lie in trying something different even if it is better. Similar pressures may discourage rigorous and transparent program outcome evaluation, especially controlled experimental study of competing practice and policy options. It may be safer to remain ignorant than to know. Perhaps this is one source of the paucity of true controlled research in this area relative to others. Over a generation ago, Donald Campbell (1969) wrote about the obstacles to innovation, transparent scientific policy evaluation, and evidence-informed social policy in a landmark paper, entitled "Reforms as Experiments." The issues he cited then remain equally current today.

### Summary

In this commentary, I have argued that evidence-informed practice and policy with teens who commit sex offenses face particular challenges. Because of this, it may be especially critical for those working in child protection to increase our advocacy for best-evidence supported practices and policies. First and foremost, we must educate the public, policy makers, and the media about the facts, not the urban myths and moral panic, surrounding these youth and their service and management needs. In general, the facts paint a far more positive picture of these youth than most of the public, the media, or our policy makers might imagine, and it will be important for us to get that message out. Even among our peers in the child welfare and juvenile justice fields, there is widespread misinformation. I believe the available facts point us in directions that are quite different from those currently embraced in some state and federal juvenile sex offender management policies and practice standards (Chaffin, in press).

When educating the public, it will be critical that we emphasize both the readily visible and less readily visible risks and benefits of particular practices and policies, and insist that these be rigorously

and transparently tested. Many current policies have the potential to do more harm than good in terms of community protection, but the harms may not become visible unless they are studied scientifically. For example, federal policy under the new Adam Walsh Act dictates that 14-year-olds in the juvenile justice system for a sex crime must come under lifetime public sex offender registration. This policy will carry cascading implications for other policies, such as automatic expulsion from school, residency restrictions and family disruption, educational disruption, employability limits, and so on. This could possibly be the single most ill-considered public policy in the history of child protection. In essence, this piece of public policy has limited potential to do good (i.e., these groups of youth pose no extraordinary risk to commit future sex crimes and account for a very small percentage of all future sex crimes) with disturbing potential to make things worse, because marginalizing and excluding groups of not unusually dangerous teens from society increases their chances to commit future crimes. Misinformation, ideology, and emotional anecdotes, rather than facts or careful analysis, dominated the policy making dialogue around this bill. We can expect nothing but more poor policy and less than optimal services until we use the science available to us to better inform our decisions.

### References

- Caldwell, M. (2007). Sexual offense adjudication and sexual recidivism among juvenile offenders. *Sexual Abuse: A Journal of Research and Treatment*, 19, 107-113.
- Campbell, D. T. (1969). Reforms as experiments. *American Psychologist*, 24, 409-429.
- Chaffin, M. (in press). 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. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children*. [Special Issue: Children With Sexual Behavior Problems].
- Hahn, R., McGowan, A., Liberman, A., Crosby, A., Fullilove, M., Johnson, R., Moscicki, E., Price, L., Snyder, S., Tuma, F., Lowy, J., Briss, P., Cory, S., & Stone, G. (2007, November 30). Effects on violence of laws and policies facilitating the transfer of youth from the juvenile to the adult justice system: A report on recommendations of the Task Force on Community Preventive Services. *MMWR Recommendations and Reports*, 56(RR09), 1-11.
- Higgins, P. A. T., Chan, K. M. A., & Ponder, S. (2006, Fall). At issue: Bridge over a philosophical divide. *APSAC Advisor*, 18, 2-4.
- Letourneau, E., & Miner, M. (2005). Juvenile sex offenders: The case against legal and clinical status quo. *Sexual Abuse: A Journal of Research and Treatment*, 17, 293-312.

### About the Author

Mark Chaffin, PhD, is a psychologist and is Professor of Pediatrics and Clinical Associate Professor of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center. He also serves as Director of Research for Developmental and Behavioral Pediatrics and is Codirector of the National Center on the Sexual Behavior of Youth. He conducts research in areas related to child abuse and neglect, including development and dissemination of evidence-based intervention models. Dr. Chaffin has served on the APSAC Board of Directors and is past editor of the APSAC journal, *Child Maltreatment*. E-mail: Mark-Chaffin@ouhsc.edu.



© SASCHA BURKARD/DREAMSTIMES.COM

## Adolescents With Illegal Sexual Behavior: Current Knowledge

Barbara L. Bonner, PhD

Adolescents with illegal sexual behavior (AISB) are typically defined as boys and girls from ages 13 to 18 who commit illegal sexual behavior as defined by the statutes of the jurisdiction in which the offense occurred. Often used for AISB is the label *juvenile sex offender*, a broader term that includes all youth under age 18 with illegal sexual behavior. To date, the term *adolescent sex offender* has been widely used for these adolescents in treatment programs, research projects, multidisciplinary training, and the literature in general. However, professionals who work with these adolescents have recommended that the term *sex offenders* not be used with youth under age 18 as it ties the adolescents too closely to the category of adult sex offenders. And, as the following paragraphs describe, there are substantial differences between adolescents and adults who commit illegal sexual behavior.

Other terms that are currently being used are *adolescents or juveniles with sexually abusive or sexually harmful behavior*. It is interesting to note that quite early in the recognition and development of interventions for children under age 12 with problematic sexual behavior, the term *children with sexual behavior problems* was adopted to clearly differentiate this group of children from older youth, but the differentiation in terms between adolescents and adults is a more recent change in the field.

Professional interest in AISB began in the 1980s with treatment programs, often modeled on programs for adult sex offenders, being established in community, inpatient, and incarcerated settings. The most recent figures show that the number of programs providing treatment to adolescents throughout the United States increased from 346 in 1986 to 937 in 2002 (McGrath, Cumming, & Burchard, 2003). Of the 937 programs, 674 provided treatment to adolescent males in community-based settings ( $N=486$ ) and in residential settings ( $N=188$ ). There were 263 programs for female AISB, with 230 in the community and 33 in more structured settings. These figures indicate that more programs provide community-based services to adolescent girls with illegal sexual behavior (87% of 263 programs) than for adolescent boys (72% of 674 programs). This may be due to the higher rates of serious sexual offenses and other delinquent behavior by adolescent boys.

Recent statistics from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) indicate some promising trends in juvenile crime in general and in illegal sexual behavior by juveniles (OJJDP, 2008). (Note: These figures include arrests for all juveniles under age 18 and not for adolescents only.) In 2006, a total of 2.2 million juveniles were arrested for all offenses, a decrease of 24% from the number in 1997, and forcible rape arrests ( $N=3610$ , 98% by males) were down 31% from 1997. There were 15,900 arrests for other sex offenses by juveniles in 2006 (excluding rape and prostitution), and 90% were committed by males (OJJDP, 2008). This figure also showed a decrease of 16% from 1997. In spite of this decline, juveniles were responsible for approximately 33% of all juvenile and adult arrests for illegal sexual behavior in 2006. These figures clearly indicate that sex offenses are primarily committed by adolescent males rather than females. Based on

these differences, this article will focus on male adolescents, and a separate article in this *Advisor* will describe adolescent females with illegal sexual behavior.

Research on adolescent males with illegal sexual behavior has focused on their characteristics, establishing a typology, their level of risk for reoffense, and their recidivism. It is notable that only a handful of studies have compared treatment approaches and only recently has a major randomized clinical trial been funded (see Letourneau & Borduin, in this issue.) Research has documented that AISB are a heterogeneous group of boys with differences in abuse history (Veneziano, Veneziano, & LeGrand, 2000); characteristics of the victims, such as age and gender (Fehrenbach, Smith, Monastersky, & Deisher, 1986); violence (Hunter, Hazelwood, & Slesinger, 2000); level of risk for recidivism (Kemper & Kistner, 2007; Parks & Bard, 2006); and treatment effectiveness (Reitzel & Carbonell, 2006).

A focus of recent publications has been to differentiate adolescents with illegal sexual behavior from adult sex offenders and children with sexual behavior problems (Chaffin, Letourneau, & Silovsky, 2002). These three groups are reported to have significant differences in their cognitive and emotional development, the etiology of the behavior, the structure and content of treatment, their risk for future problematic or illegal sexual behavior, and their reported recidivism rates.

Adolescents have been found to differ significantly from adult sex offenders in the following ways:

- AISB are considered to be more responsive to treatment than adult sex offenders and do not appear to continue reoffending into adulthood, especially when provided with appropriate treatment (ASTA, 2000);
- Adolescents have fewer numbers of victims than adult offenders and, on average, engage in less serious and aggressive behaviors (Miranda & Corcoran, 2000);
- Most adolescents do not have deviant sexual arousal and/or deviant sexual fantasies that many adult sex offenders report (Hunter, Goodwin, & Becker, 1994; Becker, Hunter, Stein, & Kaplan, 1989);
- Most adolescents are not sexual predators, nor do they meet the accepted criteria for pedophilia (APA, 2000); and
- Few adolescents appear to have the same long-term tendencies to commit sexual offenses as do some adult offenders (Caldwell, 2007).

AISB are seen as a highly diverse group of boys in their backgrounds and current functioning (Chaffin et al., 2002). Some boys are otherwise well-functioning youth with limited, if any, behavioral

Cont'd on page 6

## ADOLESCENTS WITH ILLEGAL SEXUAL BEHAVIOR: CURRENT KNOWLEDGE

or psychological problems; others have multiple nonsexual behavior problems or prior nonsexual delinquent behavior; and a small group have a major psychiatric disorder in addition to their illegal sexual behavior. Some come from well-functioning families while others come from highly problematic or abusive backgrounds, and contrary to a common assumption, the majority of adolescents with illegal sexual behavior have not been victims of childhood sexual abuse (Hanson & Slator, 1988; Widom, 1995).

### Assessment

Assessments of AISB can be conducted to develop appropriate intervention and supervision plans, to provide information about the risk of recidivism, and to inform others who are making important case decisions, such as decisions about placement, release from a facility, family reunification, and so forth. Unlike investigations, an assessment is not appropriate for determining whether someone did or did not commit a sex offense. Intervention recommendations are most often based on interviews and the youth's psychosocial and behavioral history. In some cases, the assessor may decide that additional information is needed to clarify a particular question about individual functioning. In these cases, psychological testing or other procedures may be helpful. For example, unresolved questions about the extent and focus of sexual interest patterns may be clarified by specific self-report measures.

Clinicians may be asked to conduct an assessment of an adolescent to determine if he fits the "profile" of an adolescent sex offender. It is important that clinicians know that there is no such profile and that they should clarify the purpose of the assessment. The assessment may be needed to determine if the youth can enter a treatment program or, of more concern, to determine the youth's risk of recidivism. In cases of an assessment to determine the appropriateness of a treatment program, a psychological assessment can be conducted that would include standard evaluations of intelligence, school achievement, behavior, and personality. In addition, the evaluation would obtain information on the youth's family composition, history, and functioning; his sexual history and behavior; circumstances and details of the illegal sexual behavior, motivation to change, and potential compliance with treatment (Kolko, Noel, Thomas, & Torres, 2004).

Another type of assessment, that of predicting a youth's risk for future illegal sexual behavior, is significantly more problematic and should be conducted by clinicians with high levels of expertise and a broad knowledge of the literature on risk assessment of adolescents. All professionals need to know that there are *no instruments* that can validly determine whether a particular AISB is at significant risk for future sex offenses (Hunter & Chaffin, 2005). When reporting a youth's level of risk, the report should include specific statements

about the limitations on the accuracy of predicting recidivism in AISB. Clinicians should be particularly cautious in making judgments about an adolescent's level of risk because research in this area remains limited.

### Treatment

Currently, there is professional consensus that most AISB can be treated effectively in outpatient group treatment programs that meet once a week for 8–28 months (Burton & Smith-Darden, 2000). These youth live in families, attend public schools, and participate in school activities including sports programs, musical activities, or the school newspaper. However, some adolescents with illegal sexual behavior need a structured residential or incarcerated placement that provides more intensive treatment and close supervision. Decisions about placement in residential or incarcerated settings should depend on community safety and the treatment needs of the individual adolescent. The possible negative effects of out-of-home or community placement, such as an increased risk of being socialized into a delinquent lifestyle, negative peer influences, weakening of family ties, absence of parental involvement in treatment, and disruption of normal adolescent development, should be considered when deciding to remove a youth from his home or community.



© AMY MYERS/ DREAMSTIMES.COM

Currently, many treatment programs are based on a cognitive-behavioral, psychoeducational approach. The typical curriculum addresses issues such as taking responsibility for the behavior, cognitive restructuring, social skills, prevention of future illegal behavior, relationship skills, victim awareness and empathy, and family support networks (McGrath et al., 2003). The programs utilize individual, group, and family systems approaches, have from 6 to 8 participants, and may include a parents' group as part of the program. A recent 10-year follow-up of boys who participated in a community-based, year-long group treatment program showed that the level of parental attendance at the program was a major predictor of the boys' successful completion of the program and significantly lower recidivism rates (3%) (Chaffin et al., 2007). More recently, multisystemic therapy (MST) has shown strong evidence for effectiveness in reducing future illegal sexual behavior (see Letourneau & Borduin, in this issue).

Two recent studies on recidivism of institutionalized adolescents aged 12–17 (Park & Bard, 2006) and 12–19 (Kemper & Kistner, 2007) compared three subgroups: adolescents who had illegal sexual behavior (a) with children, (b) with peers or adults, and (c) with both or mixed type offenses. The data reflected the youths' sexual and nonsexual recidivism rates. Kemper and Kistner found that

## **ADOLESCENTS WITH ILLEGAL SEXUAL BEHAVIOR: CURRENT KNOWLEDGE**

mixed type offenders were less likely to successfully complete treatment, but this group did not differ in recidivism from the other two subgroups. After approximately 5 years, the sexual recidivism rates for the three groups were 8.16% for AISB against children, 1.32% against peers/adults, and 4.76% for mixed type offenses, for an average recidivism rate of 4.74%. The nonsexual recidivism rates were much higher, reflecting previous findings. For adolescents with illegal sexual behavior with children, the reoffense rate for nonsexual illegal behavior was 38.78%, with peers/adults, the rate was 44.74%, and against both types of victims, 38.01%, for an average of 40.5%.

Parks and Bard (2006) found that the average of the three groups' recidivism rates for sexual offenses was 6.4% and 30.1% for non-sexual offenses. Using the J-SOAP-II and The Psychopathy Checklist: Youth Version (PCL:YV) (Forth, Kossen, & Hare, 2003), the authors found significant differences among the three subgroups. The mixed type adolescents consistently had higher scores on risk factor items compared with the other two groups. The Impulsive/Antisocial Behavior scale on the J-SOAP-II and the Interpersonal and Antisocial factors on the PCL:YV were found to be significant predictors of sexual recidivism. The results of these recent studies underscore two findings that have been consistent in the research literature: (a) sexual recidivism rates for AISB are typically below 10%, and (b) the risk for nonsexual recidivism is significantly higher than for future illegal sexual behavior in adolescents.

### **Ethical Issues**

Clinicians who provide treatment for AISB are frequently involved with the juvenile justice system as they provide treatment to youth who are court-ordered to participate in a treatment program. Due to court involvement and the sensitive nature of the illegal behavior, some aspects of treatment differ significantly from the treatment of nonadjudicated adolescents with psychological problems such as depression, anxiety, or PTSD. In working with AISB, clinicians are typically conducting treatment with a nonvoluntary, court-ordered population, and in these cases, a number of ethical issues can arise.

The first concern is the lack of current scientific knowledge about effective treatment interventions and the prediction of recidivism. To date, there is not a treatment intervention for AISB that has been scientifically evaluated for effectiveness. Multisystemic therapy (MST) is currently being tested in a randomized clinical trial, but the majority of AISB programs in the United States do not currently use MST. Cognitive-behavioral therapy is frequently used but its effectiveness has not been rigorously tested. In addition, there is not an instrument with established validity and reliability to accurately predict a youth's risk of recidivism. The J-SOAP-II and the ERASOR-2 are still under development and should be used with caution as they do not have established validity and reliability. Clinicians are practicing in an area without clear scientific knowledge about the effectiveness of their intervention, and given these limits, they should be cautious in predicting a youth's risk for future illegal sexual behavior or stating that one intervention is more effective than other approaches.

A second area of concern is the limits of confidentiality. Prior to conducting a clinical interview or using any assessment instruments,

clinicians need to carefully explain the limits of confidentiality to the adolescent and his caregivers. This should be done verbally and in writing so that it is clearly understood, particularly if a court-ordered evaluation is being conducted, the youth is entering a court-ordered treatment program, or child protective services are involved with the family. It is recommended that the caregiver sign forms to release information to make certain they understand that information will be provided to the probation officer, child protective services, or other court personnel if these agencies are involved with the youth. If it is indicated, permission should be obtained to receive information from other professionals who provide services to the adolescent or family. For all other individuals or agencies, such as school personnel, extended family members, or others, confidentiality should be maintained unless the caregivers give a release of information.

It should be explained to the adolescent and his caregiver that the reporting of suspected child abuse is legally required and the limits of confidentiality do not cover this information. If the youth discloses previously unreported abuse of children or that he was abused or neglected, the clinician will comply with the child abuse reporting law. This information should be provided to the family prior to asking questions that could elicit information about unreported victims or behaviors.

The clinician must have the necessary level of experience and competence to provide treatment to this group of adolescents in order not to practice outside the area of his or her competency. Clinicians should have experience working with adolescents, be knowledgeable about adolescent development, and have specific expertise in treating AISB and their families. If mental health professionals are providing treatment, it is recommended that the providers be licensed by the state in which they practice. For providers who are beginning to work with these youth, it is recommended that they provide services only if they are being closely supervised by a licensed, experienced professional with expertise in the assessment and treatment of AISB. All providers should remain current with the treatment research and use accepted approaches to evaluation and treatment.



© SHARIFF CHELAH/ DREAMSTIMES.COM

Cont'd on page 8

## ADOLESCENTS WITH ILLEGAL SEXUAL BEHAVIOR: CURRENT KNOWLEDGE

If a clinician utilizes intrusive assessment or treatment procedures, such as a plethysmograph, polygraph, aversive conditioning, or masturbatory reconditioning, the procedures should be used with caution and the research as to their effectiveness should be carefully reviewed prior to their utilization. A current review of the literature does not support the use of the plethysmograph or polygraph to reduce the recidivism rates of adolescents. In specific cases, arousal-conditioning techniques, such as masturbatory reconditioning, may be appropriate for some youth. The decision to use any intrusive method or procedure should be made on an individual case basis. (For additional information, see Hunter & Lexier, 1998.)

### Summary

In summary, clinicians working with adolescents with illegal sexual behavior are faced with numerous problems in providing ethical, effective treatment to these youth. As this is a developing field with continuing questions concerning risk assessment and the effectiveness of treatment, it is recommended that clinicians stay current on the literature regarding the assessment and treatment of the population, utilize treatment approaches that are appropriate for adolescents, and be aware of the ethical concerns that exist in this treatment field.

### References

- American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders (DSM-IV-TR)* (4th ed.). Washington, DC: Author.
- Association for the Treatment of Sexual Abusers (ATSA). (2000, March 11). *The effective legal management of juvenile sex offenders*. Retrievable from <http://www.atsa.com/ppjuvenile.html>
- Becker, J. V., Hunter, J. A., Stein, R. M., & Kaplan, M. S. (1989). Factors associated with erection in adolescent sex offenders. *Journal of Psychopathology & Behavioral Assessment*, 11, 353-363.
- Burton, D. L., & Smith-Darden, J. (2000). *1996 nationwide survey: A summary of the past ten years of specialized treatment with projections for the coming decade*. Brandon, VT: Safer Society.
- Caldwell, M. F. (2007). Sexual offense adjudication and sexual recidivism among juvenile offenders. *Sexual Abuse: A Journal of Research and Treatment*, 19(3), 107-113.
- Chaffin, M., Letourneau, E., & Silovsky, J. F. (2002). Adults, adolescents, and children who sexually abuse children. In J. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC Handbook on Child Maltreatment, Second Edition* (pp. 205-232). Thousand Oaks, CA: Sage.
- Fehrenbach, P., Smith, W., Monastersky, C., & Deisher, R. (1986). Adolescent sexual offenders: Offender and offense characteristics. *American Journal of Orthopsychiatry*, 56, 225-233.
- Forth, A. E., Kossen, D. S., & Hare, R. D. (2003). *The psychopathy checklist: Youth version*. Toronto, Ontario, Canada: Multi-Health Systems.
- Hanson, R. K., & Slater, S. (1988). Sexual victimization in the history of sexual abusers: A review. *Annals of Sex Research*, 1, 485-499.
- Hunter, J. A., & Chaffin, M. (2005). *Ethical issues in the assessment and treatment of adolescent sex offenders*. National Center on Sexual Behavior of Youth. Retrievable from NCSBY.org
- Hunter, J. A., Goodwin, D. W., & Becker, J. V. (1994). The relationship between phallometrically measured deviant sexual arousal and clinical characteristics in juvenile sexual offenders. *Behavioral Research and Therapy*, 32, 533-538.
- Hunter, J. A., Hazelwood, R. R., & Slesinger, D. (2000). Juvenile-perpetrated sex crimes: Patterns of offending and predictors of violence. *Journal of Family Violence*, 15, 81-93.
- Hunter, J. A., & Lexier, L. L. (1998). Ethical and legal issues in the assessment and treatment of juvenile sex offenders. *Child Maltreatment*, 3, 339-348.
- Kemper, T. S., & Kistner, J. A. (2007). Offense history and recidivism in three victim-age-based groups of juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 19(4), 409-423.
- Kolko, D. J., Noel, C., Thomas, G., & Torres, E. (2004). Cognitive-behavioral treatment for adolescents who sexually offend and their families: Individual and family applications in a collaborative outpatient program. *Journal of Child Sexual Abuse*, 13, 157-192.
- McGrath, R. J., Cumming, G. F., & Burchard, B. L. (2003). *Current practices and trends in sexual abuser management*. Brandon, VT: Safer Society.
- Miranda, A. O., & Corcoran, C. L. (2000). Comparison of perpetration characteristics between male juvenile and adult sexual offenders: Preliminary results. *Sexual Abuse: A Journal of Research and Treatment*, 12(3), 179-188.
- Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2008). *OJJDP Statistical Briefing Book*. Retrievable from <http://ojjdp.ncjrs.gov/ojsatbb/crime>
- Parks, G. A., & Bard, D. E. (2006). Risk factors for adolescent sex offender recidivism: Evaluation of predictive factors and comparison of three groups based upon victim type. *Sexual Abuse: A Journal of Research and Treatment*, 18(4), 319-339.
- Prentky, R., & Righthand, S. (2003). *Juvenile Sex Offender Assessment Protocol-II manual*. Unpublished manuscript.
- Reitzel, L. R., & Carbonell, J. L. (2006). The effectiveness of sexual offender treatment for juveniles as measured by recidivism: A meta-analysis. *Sexual Abuse: A Journal of Research and Treatment*, 18(4), 401-418.
- Veneziano, C., Veneziano, L., & LeGrand, S. (2000). The relationship between adolescent sex offender behaviors and victim characteristics with prior victimization. *Journal of Interpersonal Violence*, 15, 363-374.
- Widom, Cathy Spatz. (1995). *Victims of childhood sexual abuse: Later criminal consequences*. Washington, DC: U.S. Department of Justice, National Institute of Justice.

### About the Author

Barbara L. Bonner, PhD, a clinical child psychologist, is Associate Professor and Director of the Center of Child Abuse and Neglect in the Department of Pediatrics at the University of Oklahoma Health Sciences Center. She also serves as Administrator of the National Center on Sexual Behavior of Youth. Her clinical and research interests include the assessment and treatment of abused children, treatment outcome and program effectiveness, prevention of child fatalities, and treatment of children and adolescents with inappropriate or illegal sexual behavior. Dr. Bonner serves on the Board of Councilors of the International Society to Prevent Child Abuse and Neglect (ISPCAN) and is past president of APSAC. E-mail: Barbara-Bonner@ouhsc.edu.

**Typology of AISB: An Update****Keri Pierce, MPH, LCSW**

There have been several attempts to define subtypes of adolescents with illegal sexual behavior (AISB), which would allow a better understanding of their supervision needs, the etiology of the behavior, case management, their responsiveness to treatment, and their level of risk for recidivism. Clinically-based typologies may be useful in planning interventions, but they should be used with caution as they have not been empirically tested. Clinical typologies are important because they can potentially guide interventions.

Perhaps the simplest typology involves subdividing adolescents with illegal sexual behavior by the type of their offense (e.g., illegal sexual behavior against peers vs. children vs. mixed groups or others) or by characteristics of their victims (e.g., male vs. female victims, interfamilial vs. extra familial). These distinctions have been the most commonly used to date.

In general, adolescents with illegal sexual behavior against children appear to be different from adolescents who assault peers, although the behaviors are not mutually exclusive. Compared with peer rapists, adolescents who molest children have been found to be younger and have less social competence, less peer sexual activity, and fewer conduct problems (Krauth, 1998). Personality differences also have been found between these two groups, with adolescents who molest children appearing more dependent, withdrawn, and self-critical than peer rapists (Carpenter, Peed, & Eastman, 1995).

The earliest and most detailed clinical typology was developed by O'Brien and Bera (1986) from their PHASE outpatient treatment program. This typology was useful for treatment providers because it was both descriptive (i.e., describing common characteristics, backgrounds, and motivations for each type) and prescriptive (i.e., suggesting treatment targets and levels of care needed for each type). The categories were (1) naïve experimenters, (2) undersocialized child molesters, (3) narcissistic child molesters, (4) sexual aggressives, (5) sexual compulsives, (6) disturbed impulsives, and (7) group influenced. Becker and Kaplan (1988) proposed differentiating among three groups of adolescents: one with emerging paraphilic interests, a second with generalized conduct disorder, and a third with self-limited exploratory behavior. Although these typologies were useful in the development of the field, none of the clinical typologies has been empirically validated (Becker, 1998).



© MICHAŁ BEDNAREK/ DREAMSTIMES.COM

Research on the personality characteristics of these adolescents has identified some clusters that are not dissimilar from the clinical typologies discussed above. Smith, Monastersky, and Deisher (1987) identified four groups of MMPI profiles: a shy, overcontrolled and socially isolated group; a narcissistic, disturbed, insecure, and argumentative group; an outgoing, honest, yet occasionally explosive group; and an impulsive, mistrustful, and undersocialized (i.e., delinquent) group. More recent work (Worling, 2001) suggested

four somewhat similar personality clusters: an unusual and isolated group, a confident and aggressive group, an overcontrolled and reserved group, and an antisocial and impulsive group. These personality subgroups were not found to be related to sexual behavior history, but they were related to general (i.e., predominantly non-sexual) recidivism, with the antisocial-impulsive and unusual-isolated groups having higher rates of future nonsexual offenses.

In emerging typological research, Hunter (2006) has suggested that adolescents with illegal sexual behavior who molest young children may arrive at their behavior via different developmental pathways than those who offend against pubescent victims. In this study, offenders against young children, referred to as "Adolescent Onset, Non-Paraphilic," included a sizeable subset characterized by psychosocial inadequacies, an expectation of rejection and ridicule by peers, a preference for the company of younger children, and youth who primarily offended against prepubescent females. The author posited that the sexual offending by

this type of youth is experimental or opportunistic in nature. It was also hypothesized that the outcome of treatment for these youth would be positive as long as they did not become involved in drugs and with highly delinquent peers. The second subset was described as youth who engaged in oppositional and aggressive behaviors early in life and continued through adulthood. These youth were referred to as "Life Style Persistent" and were typified by youth who offend against pubescent and postpubescent females. These youth tended to have negative outcomes, with more antisocial behavior than the other groups of AISB and the highest percentage of posttreatment arrests for nonsexual reoffenses. The third group of AISB was referred to as "Early Adolescent Onset, Paraphilic"

Cont'd on page 10

## TYPOLOGY OF AISB: AN UPDATE

and was seen as developing paraphilic interests. These youth had more prepubescent male victims than the other two subtypes and were predicted to have the highest percentage of posttreatment arrests for sexual reoffenses.

### Risk Assessment

The development of an accurate typology may also have implications for risk assessment of illegal sexual behavior of adolescents. Studies comparing groups of adolescents with illegal sexual behavior have found generally low recidivism rates (Parks & Bard, 2006). Research has recently focused on developing valid risk assessment instruments for adolescents. While valid instruments have been developed and found to be successful with adult sex offenders (e.g., Barbaree, Seto, Langton, & Peacock, 2001), the development of risk assessment instruments for adolescents is still in process (Prentky, Harris, Frizzell, & Righthand, 2000; Prentky & Righthand, 2003; Worling & Curwin, 2001). Due to the generally low rates of recidivism for treated adolescents, the identification of reliable risk factors to predict recidivism is continually being refined.

The following instruments are currently under development to assess risk in male AISB:

- **Juvenile Sex Offender Assessment Protocol-2 (J-SOAP-2)** (Prentky & Righthand, 2003). This is a 28-item experimental instrument designed to assess risk in male adolescents who have been adjudicated for sexual offenses, or who have not been adjudicated but are known to have a history of sexually abusive behavior. Each of the 28 items represents a risk factor. The items are divided into four scales: Sexual Drive-Preoccupation, Impulsive-Antisocial Behavior, Intervention, and Community Stability-Adjustment. Reliability and validity data are currently being obtained for this revised version of the original

J-SOAP. (For additional information, see NCSBY.org and csom.org/pulse/JSOP.pdf.)

- **The Estimate of Risk of Adolescent Sexual Offense Recidivism-2 (ERASOR-2)** (Worling & Curwin, 2001) is an empirically guided checklist designed to estimate the short-term risk of a sexual reoffense by a youth aged 12–18. It includes dynamic (N=16) and static (N=9) items for a total of 25 risk factors. The five scales of the instrument are Sexual Interests, Attitudes, and Behaviors; Historical Sexual Assaults; Psychosocial Functioning; Family-Environmental Functioning; and Treatment. Preliminary data supported the reliability and item composition of the original ERASOR (Worling, 2004), and research is continuing on this instrument. (For additional information, see NCSBY.org and springerlink.com/index/U6542U878562J631.pdf.)

The authors note that the Erasor-2 is an instrument under development and should not be used to make predictions about adolescent recidivism at this time. While the accurate assessment of risk for future illegal sexual behavior continues to be a developing field, two factors are important to note: (a) the field is making a concerted effort to develop instruments that are valid and reliable in assessing risk in adolescents and, more important, (b) studies continue to report low recidivism rates for future illegal sexual behavior by adolescents.

### Treatment

Adolescents with illegal sexual behavior are a diverse group, and as such, it would seem likely that different types of adolescents would benefit from certain types of treatment based on their personality, offense history, developmental status, or typology. A definitive typology for these adolescents would help to determine the type



© ALEXEY TETERIN/ DREAMSTIMES.COM

## TYPOLOGY OF AISB: AN UPDATE

of treatment that would be most effective with an individual adolescent. For example, adolescents with a sex offense and a severe delinquent history might benefit more from a social ecological model, such as MST, versus a traditional, group therapy program focusing on their sexual behavior. This would allow for improved clinical outcomes and, possibly, enhanced legal management of these types of cases (Hunter, 2006). Further research is needed in this area, but until then, clinicians must rely on their judgment in designing treatment plans for these adolescents. Clinicians should be conscious of the changing nature of adolescents with illegal behaviors as they mature and be prepared to adjust treatment plans accordingly (Hunter, 2006).

### Public Policy and Legal Management

Public policy has become increasing harsh for adolescents with illegal sexual behavior, based largely on the belief that the rates of sexual reoffenses are high (Caldwell, 2002; Letourneau & Miner, 2005; Chaffin & Bonner, 1998). Even the lowest-risk adolescents with illegal sexual behavior are being subjected to harsh restrictions, such as public registrations, which may have long-term consequences (Parks & Bard, 2006). As a result of the lack of empirically-based support of risk assessment instruments and group distinctions, adolescents are being subjected to generic treatment models and harsh punishments (Parks & Bard, 2006). Based on the above discussion, it is clear that mental health and legal professionals should work together to coordinate comprehensive and individualized plans for their clients. These plans should work with the dual purpose of individualized treatment for adolescents and their families and ensuring community safety (Hunter, 2006).

### Conclusion

Adolescents with illegal sexual behavior are a diverse population with varying characteristics and levels of risk. Although more research is needed in this area, emerging research does suggest that these adolescents can be subtyped into distinct categories that may enhance treatment, risk assessment, and legal management.

### References

- Barbaree, H. E., Seto, M. C., Langton, C. M., & Peacock, E. J. (2001). Evaluating the predictive accuracy of six risk assessment instruments for adult sex offenders. *Criminal Justice and Behavior, 28*, 490-521.
- Becker, J. V. (1998). What we know about the characteristics and treatment of adolescents who have committed sexual offenses. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children, 3*, 317-329.
- Becker, J. V., & Kaplan, M. S. (1988). The assessment of adolescent sexual offenders. *Advances in Behavioral Assessment of Children and Families, 4*, 97-118.
- Caldwell, M. F. (2002). What we do not know about juvenile sexual reoffense risk. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children, 7*, 291-302.
- Carpenter, D. R., Peed, S. F., & Eastman, B. (1995). Personality characteristics of adolescent sexual offenders: A pilot study. *Sexual Abuse: A Journal of Research and Treatment, 7*, 195-203.
- Chaffin, M., & Bonner, B. (1998). Don't shoot, we're your children: Have we gone too far in our response to adolescent sexual abusers and children with sexual behavior problems? *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children, 3*, 314-316.

- Hunter, J. A. (2006). Understanding diversity in juvenile sexual offenders: Implications for assessment, treatment, and legal management. In R. E. Longo & D. S. Prescott (Eds.), *Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems* (pp. 63-77). Holyoke, MA: NEARI Press.
- Krauth, A. A. (1998). A comparative study of male juvenile sex offenders. *Dissertation Abstracts International, 58*, 4455B.
- Letourneau, E. J., & Miner, M. H. (2005). Juvenile sex offenders: A case against the legal and clinical status quo. *Sexual Abuse: A Journal of Research and Treatment, 17*, 293-312.
- O'Brien, M. J., and Bera, W. (1986, Fall). Adolescent sexual offenders: A descriptive typology. *Preventing Sexual Abuse, 4*, 1-4.
- Parks, G. A., & Bard, D. E. (2006). Risk factors for adolescent sex offender recidivism: Evaluation of predictive factors and comparison of three groups based upon victim type. *Sexual Abuse: A Journal of Research and Treatment, 18*, 319-342.
- Prentky, R. A., Harris, B., Frizzell, K., & Righthand, S. (2000). An actuarial procedure for assessing risk with juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 12*(2), 71-93.
- Prentky, R. A., & Righthand, S. (2003). *Juvenile Sex Offender Assessment Protocol-II manual*. Unpublished manuscript.
- Smith, W. R., Monastersky, C., & Deisher, R. M. (1987). MMPI-based personality type among juvenile sexual offenders. *Journal of Clinical Psychology, 43*, 422-430.
- Worling, J. R. (2001). Personality-based typology of adolescent male sexual offenders: Differences in recidivism rates, victim-selection characteristics, and personal victimization histories. *Sexual Abuse: A Journal of Research and Treatment, 13*(3), 149-166.
- Worling, J. R. (2004). The estimate of risk of adolescent sexual offense recidivism (ERASOR): Preliminary psychometric data. *Sexual Abuse: Journal of Research and Treatment, 16*(3), 235-254.
- Worling, J. R., & Curwin, T. (2001). *The 'ERASOR': Estimate of Risk of Adolescent Sexual Offense Recidivism, Version 2.0*. Unpublished manuscript. Toronto, Canada: Ontario Ministry of Community and Social Services.

### About the Author

Keri Pierce is the Director of the National Center on Sexual Behavior of Youth (NCSBY), a national training and technical assistance center developed by the Office of Juvenile Justice and Delinquency Prevention and the Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center. She has clinical experience in the treatment of preschool children with sexual behavior problems, and currently works with adolescent sex offenders. E-mail: Keri.Pierce@ouhsc.edu.

## Adolescent Girls With Illegal Sexual Behavior

Susan R. Schmidt, PhD

### Introduction

Over the past decade, illegal sexual behavior by adolescents has become a growing concern in the United States. Although most cases of illegal sexual behavior (AISB) coming to the attention of the juvenile courts involve adolescent boys, cases involving teenage girls appear to be increasing. Snyder and Sickmund (2006) reported that between 1997 and 2002, the number of juvenile cases for forcible rapes by adolescent girls rose by 6%, 62% for other violent sex offenses and 42% for nonviolent sex offenses. Despite these reported increases, adolescent girls continue to be responsible for only a small percentage of total numbers of delinquent sexual offenses (3% of forcible rapes, 5% of other violent sex offenses, 19% of nonviolent sex offenses) (Snyder & Sickmund, 2006). As a result, limited attention has been paid to understanding this population. Because much of the existing literature on adolescent girls with illegal sexual behavior was drawn from studies involving single cases and inpatient samples, it is unlikely that this information adequately represents the overall population of female AISB. Similar to their male counterparts, these girls are a diverse population with diverse needs.

### Individual Characteristics

The average female AISB is 14 years of age, which is slightly younger than the typical male AISB, and has an average IQ (Fehrenbach & Monastersky, 1988; Hunter, Lexier, Goodwin, Browne, & Dennis, 1993; Mathews, Hunter, & Vuz, 1997). Studied samples have mirrored the overall AISB population with respect to racial/ethnic diversity, with the majority being Caucasian, followed by African American and Hispanic. Although some female AISB have histories of multiple nonsexual behavior problems or prior nonsexual juvenile offenses, others are well-functioning adolescents with limited behavioral problems. Kubik, Hecker, and Righthand (2002) found that adolescent females with histories of illegal sexual behavior had significantly fewer antisocial behavior problems (e.g., substance abuse, peer violence) than juvenile females with only nonsexual offenses. However, Bumby and Bumby (1997) found an inpatient sample of female AISB to have high levels of substance abuse and previous mental health treatment. The research on female AISB is similar to that on male AISB in that the findings appear to be clearly related to the subgroup being studied (i.e., outpatient, inpatient, or incarcerated).

There is great variability in the levels of family psychopathology of these adolescents, with some girls experiencing significant family dysfunction and others having limited psychological problems (Chaffin, Letourneau, & Silovsky, 2002). A majority of female AISB have sustained more extensive and severe physical and sexual maltreatment during their childhoods than their male counterparts (Bumby & Bumby, 1997; Hanson & Slater, 1988; Hunter et al., 1993; Mathews et al., 1997). The adolescent girls with histories of childhood sexual abuse typically have been sexually victimized at younger ages, most commonly by a relative or acquaintance, and are more likely to have had multiple perpetrators. Common symptoms found in female AISB are the presence of anxious,

depressive, and posttraumatic stress related to their sexual and/or physical victimization (Bumby & Bumby, 1997; Hunter et al., 1993; Mathews et al., 1997).

### Offense Characteristics

Both genders of AISB share certain similarities with regard to illegal sexual behavior. They appear to exhibit greater variability in their sexual arousal and behavior patterns than is exhibited by adult sex offenders. Both genders engage in a variety of sexual behaviors, including exposure, fondling, oral sex, vaginal sex, and anal intercourse (Fehrenbach & Monastersky, 1988; Hunter et al., 1993; Mathews et al., 1997). Male and female children appear to be at similar risk for sexual victimization by adolescent females. Some studies found that female AISB selected female victims at a slightly higher rate than male victims (e.g., Bumby & Bumby, 1997; Fehrenbach & Monastersky, 1988). Other studies found the opposite, with males having been victimized at a somewhat higher number (e.g., Hunter et al., 1993; Mathews et al., 1997). Each study found a small percentage of females who offended against children of both sexes.

The average victim of female AISB is approximately 5 years old (Fehrenbach & Monastersky, 1988; Hunter et al., 1993; Mathews et al., 1997). A review of 183 registered juveniles with illegal sexual behavior in Texas found the average age of victims of females was 7.6 as compared with 8.4 for males (Vandiver & Teske, 2006). In addition, adolescent girls are more likely than boys to victimize children from the ages of infancy to age 5 (33% versus 22%). Both genders tend to select victims who are acquaintances or relatives. Females, however, are more likely to commit their offense within the context of a caregiving act such as babysitting (Bumby & Bumby, 1997; Mathews et al., 1997). As stated by Vandiver and Teske (2006), the combined research suggests that many female AISB are likely seeking victims of convenience rather than displaying a clear preference for victim age or gender.

### Typology

To date, Mathews and colleagues (1997) have provided the only typology to differentiate between subgroups of female AISB. Based on a sample of 67 girls, they identified three subgroups:

- Adolescent girls motivated by sexual curiosity who commit a limited number of offenses against a nonrelated child while babysitting. Girls in this group had minimal histories of abuse, family dysfunction, and mental health problems. They were described as naïve and sexually inexperienced.
- Adolescent girls with personal victimization histories who abuse younger children in a manner similar to their own victimization. They had moderate histories of abuse and personal difficulties but appeared to be functioning relatively well interpersonally.

## ADOLESCENT GIRLS WITH ILLEGAL SEXUAL BEHAVIOR

- Adolescent girls who engaged in more frequent and extensive illegal sexual behavior with children. They had more severe individual and familial dysfunction and significant early personal victimization histories.

Larger studies are needed to further evaluate the applicability of this typology within the larger population of female AISB.

### Assessment and Treatment

The current literature on AISB provides limited information on the assessment and treatment of adolescent girls. At present, there is no scientifically validated risk assessment system designed for use with this population. Although a number of risk assessment tools are being developed for use with male AISB, these instruments will require further validation to determine their applicability to adolescent girls. Caution is suggested in the use of these tools as they may overestimate the relevance of certain risk factors in girls and may underestimate or fail to identify factors that may be unique to recidivism with female AISB.

As with male AISB, a broad approach should be taken when evaluating the treatment and placement needs of adolescent girls with illegal sexual behavior. In consideration of the research indicating the high incidence of childhood sexual trauma in this population, evaluations for these adolescents should access their trauma exposure history and the presence of posttraumatic symptomatology in addition to a standardized psychological assessment (Mathews et al., 1997; Grayston & deLuca, 1999).

At present, no evidence exists to support the use of traditional male AISB treatment methods with females or the inclusion of females in male group treatment programs. Current clinical opinion suggests that the treatment needs for female and male AISB may differ with respect to such issues as victimization history, relationship development, and sexual health (Mathews et al., 1997; Grayston & deLuca, 1999). Given the variability of female AISB, it is recommended that treatment and placement decisions be made on a case-by-case basis to best meet the needs of each adolescent (Mathews et al., 1997). While the girl's illegal sexual behavior should be a significant component of therapy, other areas may be of equal importance, such as treatment for PTSD, depression, or substance use. For example, an empirically validated abuse-focused clinical intervention, such as trauma-focused cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2006), should be incorporated into the treatment plan of girls experiencing posttraumatic symptomatology related to childhood victimization.

### Conclusion

In summary, the current literature on adolescent girls with illegal sexual behavior provides only a limited picture of this diverse population. Areas in need of further investigation include the following:

- Sexual and nonsexual recidivism rates,
- Tools and methods for assessing reoffense risk,
- Further investigation into the relationship between early childhood sexual abuse and illegal sexual behavior,
- Development of methods for treating adolescents who

- are experiencing symptomatology related to personal childhood victimization, and
- Controlled outcome studies investigating the effectiveness of existing intervention methods.

### References

- Bumby, K. M., & Bumby, N. H. (1997). Adolescent female sexual offenders. In B. K. Schwartz & H. R. Cellini (Eds.), *The sex offender: Corrections, treatment, and legal practice* (pp. 10.1-10.16). Kingston, NJ: Civic Research Institute.
- Chaffin, M., Letourneau, E., & Silovsky, J. (2002). Adults, adolescents, and children who sexually abuse children. In J. Myers, L. Berliner, J. Briere, C. Hendrix, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment, second edition* (pp. 205-232). Thousand Oaks, CA: Sage.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford.
- Fehrenbach, P. A., & Monastersky, C. (1988). Characteristics of female adolescent sexual offenders. *American Journal of Orthopsychiatry*, 58(1), 41-44.
- Grayston, A. D., & deLuca, R. V. (1999). Female perpetrators of child sexual abuse: A review of the clinical and empirical literature. *Aggression and Violent Behavior*, 4(1), 93-106.
- Hanson, R. K., & Slater, S. (1988). Sexual victimization in the history of sexual abusers: A review. *Annals of Sex Research*, 1(4), 485-499.
- Hunter, J. A., Lexier, L. J., Goodwin, D. W., Browne, P. A., & Dennis, C. (1993). Psychosexual, attitudinal, and developmental characteristics of juvenile female sexual perpetrators in a residential treatment setting. *Journal of Child and Family Studies*, 2(4), 317-326.
- Kubik, E., Hecker, J., & Righthand, S. (2002). Adolescent females who have sexually offended: Comparisons with delinquent adolescent female offenders and adolescent males who sexually offend. *Journal of Child Sexual Abuse*, 11(3), 63-83.
- Mathews, R., Hunter, J. A., & Vuz, J. (1997). Juvenile female sexual offenders: Clinical characteristics and treatment issues. *Sexual Abuse: A Journal of Research and Treatment*, 9(3), 187-199.
- Snyder, H., & Sickmund, M. (2006). *Juvenile offenders and victims: 2006 national report*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Vandiver, D. M., & Teske Jr., R. (2006). Juvenile female and male sex offenders: A comparison of offender, victim, and judicial processing characteristics. *International Journal of Offender Therapy and Comparative Criminology*, 50(2), 148-165.

### About the Author

Susan Schmidt, PhD, is a psychologist at the Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center. Her clinical and research interests include children exposed to domestic violence, evidence-based interventions for trauma-exposed children, treatment outcome and program effectiveness, and treatment of adolescents with inappropriate or illegal sexual behavior. E-mail: Susan-Schmidt@ouhsc.edu.

## Multisystemic Therapy: Treatment for Adolescents With Delinquent Sexual Behavior

**Elizabeth J. Letourneau, PhD and Charles M. Borduin, PhD**

Multisystemic therapy (MST) (Henggeler & Borduin, 1990; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) is an evidence-based treatment model for severely delinquent youth that has been adapted for use with adolescents with illegal sexual behavior. This adaptation was completed for two main reasons. First, research shows that these adolescents have more in common with other delinquents than is generally assumed (Butler & Seto, 2002; Ronis & Borduin, 2007; van Wijk et al., 2005). Such findings suggest that effective treatments for delinquency hold promise for adolescents who sexually offend. With 10 published randomized trials with delinquents and their families (for review see Henggeler, Sheidow, & Lee, 2007), MST has relatively well-established effectiveness with the delinquent clinical population (National Institutes of Health, 2006). Second, and as described in greater detail in this article, results from three MST randomized studies suggest that MST holds considerable promise for adolescents with illegal sexual behavior (Borduin, Henggeler, Blaske, & Stein, 1990; Borduin & Schaeffer, 2001; Henggeler et al., 2008; Letourneau et al., 2008).

The following paragraphs provide a brief overview of MST in general, the adaptation of MST for youth with illegal sexual behavior, and the results of these studies.

### Overview of MST

The theoretical foundation of MST draws upon the identified correlates/causes of serious antisocial behavior and Bronfenbrenner's (1979) social-ecological theory of behavior. Social-ecological theory views the youth and family's school, work, peers, and community as interconnected systems with dynamic and reciprocal influences on the behavior of family members. Problem behavior can be maintained by problematic transactions within and/or between any one or any combination of these systems. Thus, consistent with both the empirically established correlates/causes of youth delinquent behavior and with social-ecological theory, MST interventions target identified youth and family problems within and between the multiple systems in which family members are embedded. The provision of MST in youths' homes is consistent with the family preservation model of service delivery (Nelson & Landsman, 1992), based on the philosophy that the most effective and ethical route to helping youth is through helping their families. Interventions delivered in the family's natural environment (home, school, neighborhood) optimize ecological validity and decrease barriers to service access. In our experience, working with families on their own "turf" sends a message of therapist commitment and respect that can greatly facilitate family engagement and the development of a therapeutic alliance—prerequisites for achieving desired outcomes.

The overriding goals of MST are to empower parents with the skills and resources needed to independently address difficulties that arise in raising adolescents and to empower adolescents to cope with familial and extrafamilial problems. MST therapists are trained to identify the primary drivers of a given youth's problem behavior and address the most proximal drivers with evidenced-based interventions. Because different contributing factors are relevant for different youths and families, MST interventions are individualized and highly flexible. Thus, MST does not follow a rigid protocol in which therapists conduct sets of predetermined tasks in an invariant sequence. Rather, treatment principles guide therapists' case conceptualizations, prioritization of interventions, and implementation of intervention strategies in MST. Detailed descriptions of these principles, and examples that illustrate the translation of these principles into specific intervention strategies, are provided in a clinical volume (Henggeler & Borduin, 1990) and a treatment manual (Henggeler et al., 1998).



© MARZANNA SYNCERZ/DREAMSTIMES.COM

Treatment fidelity in MST is maintained by weekly group supervision meetings involving three to four therapists per team (with caseloads of six families per therapist) and a master's- or doctoral-level clinical supervisor responsible for 1–2 MST teams. During supervision meetings, the treatment team reviews the goals and progress of each case to ensure the multisystemic focus of therapists' intervention strategies and to identify obstacles to success. It is important that the treatment team accepts responsibility for engaging families in treatment

and for effecting therapeutic change. Fidelity is measured as part of a built-in rigorous quality assurance system in which caregivers are contacted monthly to complete a standardized measure of therapist adherence to the MST model. Several research studies have supported the link between therapist adherence and youth outcomes (e.g., Schoenwald, Sheidow, & Letourneau, 2004). Although on-site clinical supervisors provide immediate oversight, support, and problem-solving help to the MST team, MST consultants also (a) review weekly case summaries, (b) hold a 1-hour phone meeting with the team each week, and (c) conduct quarterly in-person booster sessions to ensure that the assessment, intervention, and problem-solving strategies are developed and executed by the team in a manner consistent with MST principles and processes.

### Adaptation of MST for Youth With Problem Sexual Behaviors

As noted, MST interventions for adolescent antisocial behavior are specified in a clinical volume (Henggeler & Borduin, 1990) and a treatment manual (Henggeler et al., 1998) that describe the empirical, conceptual, and philosophical bases of MST and delineate the process by which youth and family problems are prioritized and targeted for change. To more fully account for clinical issues relevant to youth who have sexually offended, investigators have adapted MST for use with this population, specified the adaptation in a supplemental therapists' training manual (Borduin, Schaeffer, & Heiblum, 2007), and developed a training program for therapists and supervisors. Most important, MST for adolescents with illegal sexual behavior maintains a broad focus on the many correlates associated with juvenile delinquency generally, but it goes beyond standard MST by specifically focusing on aspects of the youth's ecology that are functionally related to the youth's sexual delinquency. For example, the adaptations to MST include creating a safety plan to minimize the youth's access to potential victims, addressing youth and caregiver denial about the offense (and/or offense severity), and improving youth's peer relations so that more age-appropriate and normative experiences can occur.

MST teams working with adolescents with illegal sexual behavior have varied somewhat from more traditional MST teams. For the three randomized clinical trials (RCT) in which MST was examined for this population (Borduin et al., 1990; Borduin & Schaeffer, 2001; Letourneau et al., 2008), MST therapists were almost uniformly master's-level clinicians, and the supervisors were doctoral-level clinicians (with Dr. Borduin serving as supervisor for the two previous RCTs). In the most recent trial, the expert consultants were Drs. Borduin and Letourneau, both of whom collaborated on the adaptation of MST for adolescents with delinquent sexual behavior.

Another aspect on which the traditional and the adapted MST interventions differ is the level of community stakeholder support that is required for implementing the intervention. Treatment for these adolescents is, in many states, regulated by state oversight bodies or Sex Offender Management Boards (SOMBs), and the procedures specified by such bodies are often at odds with the systemic focus of MST (e.g., requiring group-based interventions and/or interventions that focus primarily on individual youth-level factors). Obtaining approval from SOMBs might be a necessary precondition to providing MST to these adolescents in a given locale. Strong support from juvenile justice stakeholders also is required to support referrals to a "nontraditional" intervention (albeit one with more empirically rigorous evidence than any other intervention for this population) and (in the context of the three RCTs) to support randomization to treatment conditions. Such stakeholders will likely include judges, state's attorneys, and key

personnel in juvenile justice and juvenile probation departments. In our experience, the process of obtaining and maintaining the goodwill of this large group of stakeholders has not been as daunting as might be assumed, even during changes in leadership. Most stakeholders voiced a desire for additional treatment strategies for this population and supported efforts toward this goal.

### Evidence Supporting MST With Juveniles Who Sexually Offend

Across the entire research base examining treatment outcomes for adolescents with illegal sexual behaviors, just four randomized clinical trials (RCT) have been identified. Three compared MST with usual services provided to youth at the time of each study. Although modest in scope and size ( $N = 16$ ), Borduin and colleagues (Borduin et al., 1990) published the first randomized trial with these adolescents. Youth and their families were randomly assigned to treatment conditions: home-based MST delivered by clinical psychology doctoral students versus outpatient individual therapy (i.e., an eclectic blend of psychodynamic, humanistic, and behavioral approaches) delivered by community-based mental health professionals. Recidivism results at 3-year follow-up were encouraging. Significantly fewer youths in the MST condition were rearrested for sexual crimes (12.5% vs. 75.0%), and the mean frequency of sexual rearrests was considerably lower in the MST versus the usual services condition (0.12 vs. 1.62). Furthermore, the mean frequency of rearrests for nonsexual crimes was significantly lower for the youths who received MST (.62) than for counterparts who received outpatient therapy (2.25). These favorable effects supported the viability of conducting a second evaluation of MST with this clinical population.



© MONKEY BUSINESS/ DREAMSTIMES.COM

In a recently completed clinical trial, 48 youths who had been arrested for delinquent sexual behaviors (i.e., rape/sexual assault or molestation of younger children) were randomly assigned to MST ( $n = 24$ ) or usual services ( $n = 24$ ) (Borduin & Schaeffer, 2001; Borduin et al., 2007). In this study, MST was delivered by graduate students in clinical psychology who averaged 1.5 years of direct clinical experience with children or adolescents. The usual services condition included a combination of cognitive-behavioral group and individual treatment administered in a juvenile court setting, and treatment was delivered by master's-level therapists who averaged approximately 6 years of experience working with adolescents. Compared with those who received usual services, adolescents who received MST showed improvements on a range of instrumental outcomes immediately following treatment, including fewer behavioral problems, less delinquent behavior, improved peer relations, improved family relations, and better grades in school. An 8.9-year posttreatment follow-up of ultimate outcomes (Borduin et al., 2007) revealed that MST participants were significantly less likely than their usual-services counterparts to be rearrested

Cont'd on page 16

## MULTISYSTEMIC THERAPY

for sexual (8.3 vs. 45.8%) and nonsexual (29.2% vs. 58.3%) offenses. MST participants had 83% fewer rearrests for sexual crimes (average 0.13 vs. 0.79 arrests) and 70% fewer rearrests for other crimes (average 1.46 vs. 4.88 arrests) than did those receiving usual services. MST youth also spent on average 75% fewer days (22.50 vs. 97.50 days) in youth detention facilities and 80% fewer days (365.00 vs. 1842.50 days) in adult detention facilities.

The results from these two relatively small-scale efficacy studies supported the potential of MST as an effective community-based treatment for adolescents with illegal sexual behavior. Thus, a third study (S. W. Henggeler, PI) was designed to provide a rigorous *effectiveness* trial of MST with this population. The two aforementioned trials conducted by Borduin and his colleagues were primarily efficacy studies. Although participants with a wide variety of co-occurring problems were included, the therapists were university-based doctoral students in clinical psychology, and the principle investigator provided the clinical training and supervision. In contrast, in the most recent RCT, community-based MST services were provided by an existing local provider agency and were funded by local justice resources. Thus, the present study represents an important step in bridging the gap between science and practice (National Institute of Mental Health, 1999) for this clinical population. Additionally, in this effectiveness trial (Letourneau et al., 2008), care was taken to include a comparison condition that is typical of the community-based services provided to these U.S. adolescents (see Letourneau & Borduin, *in press*). Significantly for the present purposes, the individual focus of treatment and the group-oriented delivery of the control condition contrasted well with the family-based and ecological emphases of MST.

The primary aim of this third RCT was to conduct a rigorous community-based effectiveness trial in which MST adapted for this group of adolescents was compared with the type of group-based services that are typically provided to these youth in the United States. The implementation of the study was successful, with strong and consistent collaboration from juvenile justice authorities, sustained clinical efforts from the private agency providing the adapted MST treatment, and high rates of participant clinical and research retention. RCTs are complex and require strong buy-in

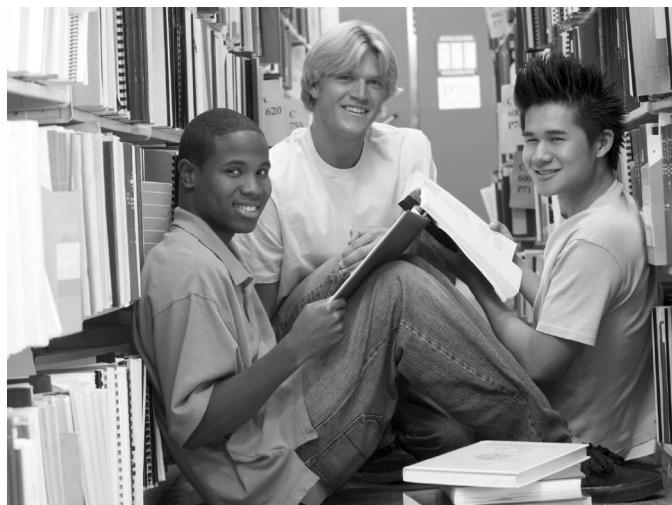
from multiple stakeholders. In the present study, the support of numerous stakeholders from the county State's Attorneys Office (e.g., Chief of Juvenile Justice, Chief of Delinquency, Supervising Attorney for the Delinquency Divisions), the circuit court (i.e., presiding judge), and the Probation Department (i.e., Director of Juvenile Probation as well as the Chief Probation Officer and Probation Supervisor) was critical to the successful implementation of this trial.

In this RCT, 127 youth and families (74% recruitment rate) were treated by five therapists (one doctoral level, three master's level, and one bachelor's level therapist, who also was bilingual). The average treatment length was 7 months, significantly longer than the typical 4-month duration of MST delivery but consistent with Borduin and colleagues' previous trials with this population. Whether the extended treatment duration is due to treatment needs of these youth and families or idiosyncratic aspects of the three studies has yet to be examined.

Intent-to-treat analyses supported the ability of MST to achieve desired outcomes through 1-year postrecruitment. These results are described in detail in two recent manuscripts (Henggeler et al., 2008; Letourneau et al., 2008). Briefly, MST was more effective than the treatment-as-usual control condition in decreasing deviant sexual interest and risk behaviors, delinquent and substance use behaviors, externalizing problems, and costly out-of-home placements. Although sexual recidivism was not examined in the present study due to low rates of short-term reoffending (as noted previously), the favorable 1-year findings for MST are consistent with the long-term reductions in sexual reoffending observed in Borduin and colleagues' two prior MST efficacy studies (Borduin et al., 1990; Borduin et al., 2007).

### Clinical and Policy Implications

In combination, the findings from these three RCTs have important clinical and policy implications. The generally favorable outcomes for the MST conditions across studies support the viability of community-based and family-focused interventions that address the known risk factors of serious antisocial behavior across multiple ecological systems in which youth are embedded. The evidence-based practices that have emerged in the treatment of other types of serious antisocial behavior in adolescents have usually been family-based and comprehensive in nature. As such, the present findings are congruent with the growing consensus that family-focused interventions targeting multiple ecological systems are among the most supported interventions for serious behavior problems, including child sexual behavior problems (St. Amand, Bard, & Silovsky, *in press*), serious juvenile delinquency (Elliott, 1998), and adolescent substance abuse and dependence (Waldron & Turner, *in press*). However, current results supporting MST appear to run counter to the spirit of using increasingly severe legal consequences (e.g., lifetime public registration, prolonged residential treatment) for many adolescents with delinquent sexual behavior (Chaffin, *in press*). Clinical findings such as those presented here, in conjunction with emerging findings that deterrent-oriented sexual offender registries for adolescents do not influence sexual recidivism rates (Letourneau & Armstrong, 2008), can be used to promote a more strength-focused and rehabilitative approach to addressing the needs of adolescents with delinquent sexual behavior.



© MONKEY BUSINESS/ DREAMSTIMES.COM

## MULTISYSTEMIC THERAPY

### References

- Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, 34(2), 105-113.
- Borduin, C. M., & Schaeffer, C. M. (2001). Multisystemic treatment of juvenile sexual offenders: A progress report. *Journal of Psychology and Human Sexuality*, 13(3-4), 25-42.
- Borduin, C. M., Schaeffer, C. M., & Heilblum, N. (2007). Multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. Manuscript submitted for publication.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature*. Cambridge, MA: Harvard University Press.
- Butler, S. M., & Seto, M. C. (2002). Distinguishing two types of adolescent sex offenders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(1), 83-90.
- Chaffin, M. (in press). Our minds are made up: Don't confuse us with the facts. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children* [Special Issue: Children With Sexual Behavior Problems].
- Elliott, D. S. (Series Ed.). (1998). *Blueprints for violence prevention* (University of Colorado, Center for the Study and Prevention of Violence). Boulder, CO: Blueprints Publications.
- Henggeler, S. W., & Borduin, C. M. (1990). *Family therapy and beyond: A multisystemic approach to treating the behavior problems of children and adolescents*. Pacific Grove, CA: Brooks/Cole.
- Henggeler, S. W., Letourneau, E. J., Chapman, J. E., Borduin, C. M., Schewe, P. A., & McCart, M. R. (2008). Mediators of change for multisystemic therapy with juvenile sexual offenders. Manuscript submitted for publication.
- Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford.
- Henggeler, S. W., Sheidow, A. J., & Lee, T. (2007). Multisystemic treatment (MST) of serious clinical problems in youth and their families. In D. W. Springer & A. R. Roberts (Eds.), *Handbook of forensic mental health with victims and offenders: Assessment, treatment, and research* (pp. 315-345). New York: Springer Publishing.
- Letourneau, E. J., & Armstrong, K. (2008). Recidivism rates for registered and nonregistered juvenile sexual offenders. Manuscript submitted for review.
- Letourneau, E. J., & Borduin, C. M. (in press). The effective treatment of juveniles who sexually offend: An ethical imperative. *Ethics and Behavior*, 18(3-4).
- Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., Chapman, J. E., & Saldana, L. (2008). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. Manuscript submitted for review.
- National Institute of Mental Health. (1999). *Bridging science and service*. [NIH Publication No. 99-4353]. Washington, DC: Author.
- National Institutes of Health. (2006). National Institutes of Health State-of-the-Science Conference Statement: Preventing violence and related health-risking, social behaviors in adolescents, October 13-15, 2004. *Journal of Abnormal Child Psychology*, 34(4), 457-470.
- Nelson, K. E., & Landsman, M. J. (1992). *Alternative models of family preservation: Family-based services in context*. Springfield, IL: Charles C. Thomas.
- Ronis, S. T., & Borduin, C. M. (2007). Individual, family, peer, and academic characteristics of male juvenile sexual offenders. *Journal of Abnormal Child Psychology*, 35(2), 153-163.
- Schoenwald, S., Sheidow, A. J., & Letourneau, E. J. (2004). Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. *Journal of Clinical Child and Adolescent Psychology*, 33(1), 94-104.
- St. Amand, A., Bard, D., & Silovsky, J. F. (in press). Treatment of child sexual behavior problems: Practice elements and outcomes. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children* [Special Issue: Children With Sexual Behavior Problems].
- van Wijk, A., Loeber, R., Vermeiren, R., Pardini, D., Bullens, R., & Doreleijers, T. (2005). Violent juvenile sex offenders compared with violent juvenile nonsex offenders: Explorative findings from the Pittsburgh Youth Study. *Sexual Abuse: A Journal of Research and Treatment*, 17, 335-352.
- Waldron, H. B., & Turner, C. W. (in press). Psychosocial treatments for adolescent substance abuse: A review and meta-analysis. *Journal of Clinical and Adolescent Psychology* [Special Issue: Evidence-Based Psychosocial Interventions for Clinical Child and Adolescent Disorders].



© GODFER/DREAMSTIMES.COM

### About the Authors

Elizabeth J. Letourneau, PhD, is a clinical psychologist and Associate Professor in the Family Services Research Center, Department of Psychiatry and Behavioral Sciences, at the Medical University of South Carolina. Her research and clinical work have focused on the assessment and treatment of sex offenders and she has published widely on this topic. E-mail: letouej@musc.edu

Charles M. Borduin, PhD, is Professor in the Department of Psychological Sciences at the University of Missouri-Columbia. He is also Director of the Missouri Delinquency Project, established in 1983 to provide treatment to juvenile offenders in the natural environment and to train mental health professionals to provide such treatments, including multisystemic therapy (MST). E-mail: BorduinC@missouri.edu.

**Journal Highlights****Tamara Davis, PhD and Beth Ann Rodriguez, MSW****Factors Predicting Adolescent Sexual Reoffending**

In this systematic review, the authors examined research literature studying recidivism among adolescent sexual offenders. Specifically, the authors sought to identify those factors found to be reliable predictors of recidivism. Though largely described as an inadequate measure of recidivism, reconviction of a sexual offense is the most common measure used to study sexual recidivism. Studies in this review also included measures of adolescent self-report or re-arrest.

Using a variety of key terms, the authors searched Psychoinfo [*sic*], Medline, and the Cochrane Library for studies to be used in the review. Articles selected had to comprise youth ages 12–21 years and be published post-1990 and pre-2003. Of the 20 identified published studies of recidivism of adolescent sexual abusers, 12 studies (totaling 1,315 juvenile sexual abusers) met selection criteria and were included in the review.

The mean age of youth in the majority of studies was 15.12 (SD 1.15), and most study samples involved youth identified as child abusers, rapists, and exhibitionists. Sexual offenders in all studies received specialized treatment, mostly based on cognitive behavioral interventions. Comparison groups were included in only four studies. The mean follow-up time across studies was 5½ years, with a mean base rate for sexual recidivism of 14%. General offender recidivism among the study samples was much higher.

Noting challenges with using reconviction as an accurate measure, the authors found that the incidence of sexual recidivism significantly increased with follow-up time. This finding reflects those reported in earlier studies. Ten of the studies reviewed also examined factors potentially associated with sexual recidivism. Three risk factors were found to be significantly related to sexual recidivism: previous sexual and/or nonsexual offenses, presence of multiple victims, and perpetration of stranger victims. Rates of sexual recidivism were lower than those for general nonsexual recidivism. Nonsexual recidivism was more highly predicted by psychopathy, antisocial behavior, or early onset conduct disorder than sexual recidivism.

Gerhold, C. K., Browne, K. D., & Beckett, R. (2007). Predicting recidivism in adolescent sexual offenders. *Aggression and Violent Behavior, 12*(4), 427–438.

**An Ecological Approach to Defining and Assessing Sexually Abusive Behavior**

In this conceptual article the authors discussed a specific tool designed to define and comprehensively assess youth identified as sexually abusive. The instrument, designed by the second author, is the *Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Children and Adolescents (MEGA)*. The article provides an overview and supportive discussion of the elements comprising the tool and its application with child and adolescent sexual offenders.

The development of the *MEGA* is predicated upon the authors' contentions that existing measures to assess sexually abusing young people do not adequately define sexually abusive behavior for all youth under age 19, do not assess youth's existing protective factors, and thus do not provide the comprehensive assessment necessary for designing appropriate interventions. Ecological systems theory is used as a basis for measurement elements. The authors suggested that in contrast to existing tools, the *MEGA* is appropriate for all youth under 19 regardless of developmental ability, is not limited to males, and may be administered by both clinical and nonclinical practitioners in a variety of treatment settings.

The instrument comprises seven aggregate domains, each addressing both risk and protective factors. These domains include neuropsychological functioning, family background, history of antisocial behavior, nonconsensual sexual incidents, degree of sexual coercion, intent/motivation of sexual behavior, and relationship (i.e., predatory nature) of youth to victim(s). The neuropsychological domain is noted as an integral component of the instrument. While no psychometric properties were offered in this article, the authors noted that the instrument is currently undergoing empirical testing.

Rasmussen, L. A., & Miccio-Fonseca, L. C. (2007). Paradigm shift implementing *MEGA*, a new tool proposed to define and assess sexually abusive dynamics in youth ages 19 and under. *Journal of Child Sexual Abuse, 16*(1), 85–106.

**Institutionalized Thinking Impacts Treatment of Juvenile Sexual Offenders**

This article used a case study approach to offer a compelling discussion of how codified definitions of appropriate juvenile sexual behavior intersected with institutional decision-making processes to impact legal determinations of juvenile sexual offenders. The author examined data from a previously reported study (Steen, 2001) within Douglas' (1986) theoretical framework of institutional thinking to examine the management of juvenile sex offenders in one county of Washington State. Steen defined institutional thinking as "the dominant assumptions guiding the work of individuals within the institution" (p. 32).

The article provides background information on Washington's legislation and practices governing juvenile sexual offenses, followed by a description of data collection and analysis methods as initially gathered and then applied to this case study. Results and discussion focus on a few key findings. The first is that medical assumptions dominated institutional thinking. That is, juvenile sex offenses were viewed in terms of psychopathology rather than as a potentially isolated incident and, as such, demanded a comparable (typically, long-term) treatment response. Second, even though individuals within the system questioned institutional thinking, their subsequent actions remained consistent with institutional thought and reflected a tendency to ignore the observed contradictions.

The third key finding reflects a pattern whereby individual perceptions of the seriousness of offending behaviors increased as participants engaged in discussion with institutional colleagues.

In effect, decision makers “work[ed] collectively to redefine sex offenses and underlying problems,” which ultimately led to decisions for longer treatment programs. The final finding suggests that rather than fitting a punishment (i.e., treatment) to the crime, institutional thinking in this Washington County tended to lead decision makers to redefine the crime (typically, as more serious) to justify a preferred mode of punishment. Noted exceptions to these last two findings were actions taken by defense attorneys who did not submit to the observed institutional thinking. The author concludes by suggesting that attention to the observed discrepancies between juvenile sexual crimes and subsequent punishment is warranted.

Steen, S. (2007). Conferring sameness: Institutional management of juvenile sex offenders. *Journal of Contemporary Ethnography*, 36(1), 31-49.

### Causal Pathways to Predicting Adolescent Male Sexually Offending Behavior

This study used a causal pathway model to examine how types and levels of childhood maltreatment were related to personality traits in predicting sexually coercive behavior in adolescent male sexual offenders. Child maltreatment (the identified predictors or independent variables) included sexual abuse, physical abuse, emotional abuse, and caregiver instability. Personality traits (the dependent variables) included psychopathy, sexual inadequacy, sexual fantasy, child fantasy, and victim outcome. The researchers hypothesized that severity of maltreatment impacts the development of the personality traits, which, in turn, predict adolescent sexual coercion against younger victims.

The study sample included 329 adjudicated juvenile sex offenders from inpatient treatment facilities in four states of the United States. The ethnically diverse sample of participants had an average age of 15.17 years, an average of 3.43 arrests, and a 1–2 year average period of commitment. Data were collected from youth over a 5-year timeframe. The study's measures were constructed from the Multidimensional Assessment of Sex and Aggression (MASA), an inventory developed and tested by the researchers.

Results largely supported the predictive model. That is, previous child maltreatment of sex offenders along with specific personality traits predicted sexual offending against younger victims. Four pathways emerged as significant in the model and support the roles emotional abuse (particularly parental antipathy) and physical abuse play in predicting psychopathy, sexual inadequacy, sexual fantasy, and/or child fantasy, ultimately leading to child victims. The key role of emotional abuse is specifically noted. A significant direct path was found from youth who had been sexually abused to their subsequent abuse of child victims.

The authors suggested that an enhanced understanding of youths' early relationships with caregivers and previous maltreatment experiences were critical factors for planning treatment. Given findings related to emotional abuse and caregiver antipathy, treatment should consider related impacts on youths' psychological status. Finally, the authors made suggestions for improving risk-assessment processes.

Daversa, M. T., & Knight, R. A. (2007). A structural examination of the predictors of sexual coercion against children in adolescent sexual offenders. *Criminal Justice and Behavior*, 34(10), 1313-1333.

### Reliability and Validity of Sexual Offending Risk Assessment Measures

The authors of this article contended that existing measures assessing risk for sexual offense have not undergone adequately rigorous testing to ensure their predictive validity. This study sought to test and compare three existing measurement tools for their ability to predict sexual and nonsexual violence in male juvenile sexual offenders. The sample included 169 males placed in a residential treatment facility for sexually abusive adolescents. All participants had been adjudicated for sexual or nonsexual offenses, were ordered into treatment, and had been discharged from treatment no less than 250 days before data were collected. Average age upon placement was 15.37 years. Most youth, 83.4%, were non-Hispanic Caucasian.

Participant case files were reviewed to complete three instruments: J-SOAP-II, J-SORRATT-II, and SAVRY. Data gathered also included youth violence during treatment (sexual and nonsexual) and after discharge. Results indicated that the J-SORRATT-II did not significantly predict either sexual or nonsexual aggression during treatment or postdischarge reoffense. The J-SOAP-II predicted nonsexual aggression during treatment, but not sexual aggression; it did not significantly predict any type of reoffense. The SAVRY predicted nonsexual aggression, but not sexual aggression during treatment; it predicted only serious nonsexual violent offenses postdischarge. The J-SOAP-II predicted serious nonsexual violent offenses better for older youth than younger youth. However, the J-SOAP-II and SAVRY yielded a significantly higher number of false positives for younger youth in predicting all types of violent offenses. In sum, none of the tools was able to significantly predict sexual offenses during or after treatment.

Based on the findings, the authors suggested that researchers should rethink the practice of including both sexual offending and nonsexual offending behaviors on measures assessing risk of offense and, instead, measure one or the other. They further suggested a closer examination of the relevance of age and developmental differences in determining risk for sexual reoffending. Finally, given the limited nature of current risk assessment tools, the authors questioned both legal and treatment decisions being made related to risk for sexual reoffending.

Viljoen, J. L., Scalora, M., Cuadra, L., Bader, S., Chávez, V., Ullman, D., et al. (2008). Assessing risk for violence in adolescents who have sexually offended: A comparison of the J-SOAP-II, J-SORRATT-II, and SAVRY. *Criminal Justice and Behavior*, 35(1), 5-23.

### Using the J-SOAP-II Risk Assessment With Ethnically Diverse Adolescents

Authors of this article suggested that current actuarial measures for assessing risk of sexual offense lack empirical support. Thus, this study sought to contribute to validating the J-SOAP-II risk assessment measure for adolescent sexual reoffense. The authors noted that initial research conducted on the J-SOAP-II included a sample of primarily Caucasian offenders; the current study's sample included primarily minority sexual offenders. In contrast to juveniles in residential care typically included in other studies, the 60 male youth in this study were drawn from a community-

Cont'd on page 20

## JOURNAL HIGHLIGHTS

based adolescent sex-offender treatment program. The average age of youth was 14.9 years. The sample included 50% Latino, 28.3% African American, and 16.7% Caucasian participants.

The J-SOAP-II was completed by the first two authors (who are also clinicians at the treatment program) based on data from clinical intake records; outcome data were gathered from treatment records. A variety of sources were used to determine evidence of sexual reoffense. Participants were reported to have received an average of 95 treatment sessions ( $SD = 83.3$ ), although the actual average length of time (e.g., months, years) in care was unclear. Results indicated a "moderate level of predictive accuracy" for the J-SOAP-II total score and any sexual reoffense. Analyses indicated that the Dynamic Summary scale contributed significantly more than the Static Summary scale in predicting sexual reoffense.

As a result of the findings, the authors suggested that more attention should be given to dynamic variables (e.g., response to treatment, life changes, community support) in assessing risk for reoffense. However, the authors also noted that their sample of lower-risk adolescents in community-based care versus higher-risk adolescents in residential care may have contributed to some of their findings. Beyond their noted limitations of the study, the authors suggested that some of their nonsignificant findings on the Static subscales may be related to the ethnic makeup of their sample compared with findings in primarily Caucasian samples of previous research on the J-SOAP-II.

Martinez, R., Flores, J., & Rosenfeld, B. (2007). Validity of the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) in a sample of urban minority youth. *Criminal Justice and Behavior, 34*(10), 1284-1295.

### Rehabilitation Versus Punishment for Juvenile Sexual Offenders in South Australia

This study was part of a larger project called the Sexual Assault Archival Study (SAAS), which sought to examine "the appropriateness of restorative justice in cases of youth sexual violence" (p. 376). The authors analyzed transcripts of 55 (out of an original 385) juvenile sexual offense cases sentenced by judges in South Australia from 1995 to 2001 for which judicial sentencing remarks were available. The researchers used a combination of deductive and inductive approaches to analyze the "judges' orientations and aims" in sentencing, "how judges reconcile the seriousness of offending and the youthfulness of offenders," and how judges "balance the competing interests of victims and offenders" (p. 371).

Content analysis revealed that case sentencing fell into three thematic categories: (1) Youth whom the judges felt were future sexual offenders, all cases with victims under age 12 and all cases with sibling victims. While sexual offenses against children were considered serious and judges were concerned about future offenses, judges' sentencing took a rehabilitative rather than a punitive approach. All of these offenders were sentenced to a treatment program that specialized in treating youth sexual offenders. (2) Antisocial and persistent offenders who concerned the judges not because of their sexual offenses but because of their general criminal behavior. In these cases, the judges felt that punishment, and perhaps some therapeutic intervention for substance abuse and mental health issues, was appropriate. (3) Judges viewed cases as less serious, were characterized as adolescent experimentation by immature offenders

who did not need intervention. The authors noted categories (1) and (3) were consistent with previous literature; category (2) was not usually cited in literature.

The authors suggested that judicial sentences reflected consideration of the seriousness and context of the offense and the characteristics of the victims and the offenders. The primary focus of the judges was to stop future sexual offenses by (a) addressing what they believed to be the cause of the behavior and (b) by persuading the offenders to comply with the social norms. Finally, the authors concluded that this study confirms other studies; that is, most youth courts in Western nations (with the possible exception of the United States) continue to focus on rehabilitation rather than punitive action for juvenile sexual offenders.

Bouhours, B., & Daly, K. (2007). Youth offenders in court: An analysis of judicial sentencing remarks. *Punishment & Society, 9*(4), 371-394.

### A Treatment Model for Juvenile Male Offenders

This article described a treatment program developed by the author and a treatment agency to treat juvenile sex offenders in residential treatment settings. While the author did not indicate that the model itself had been tested, she asserted that it is a "research-based treatment program" that integrates theory, national standards, and prior research conducted by other scholars to address factors related to juvenile sexual offending behaviors. She combined the 12 recommended treatment components of juvenile sex offender treatment programs outlined in 1993, by the National Task Force on Juvenile Sex Offending (NTFSO), with cognitive-behavioral theory to create 7 sequential modules of treatment. The article described each module's purpose, activities used, youth's tasks and challenges, and counselor's tasks and tools.

Activities in the first treatment module, Disclosure of the Committing Offense and Taking Responsibility for Actions, reflect the first steps in helping the youth take responsibility for the offense and for rehabilitation. Cognitive Autobiography explores the youth's developmental process and identifies significant issues and events. This treatment module is followed by Affective Autobiography and Trauma History, which explores the affective components of development, including attachment, significant relationships, and trauma. The fourth treatment module is History of Delinquency, Sexuality, and Substance Abuse. This module examines the causes of each treatment issue and how it interrelates. The counselor examines the youth's sexual development and explores the causes of sexual offending.

The Offense Cycle is the core of the treatment program. It bridges past treatment work and historical factors with a plan for successfully moving into the future. It is based on the premise that sexual offending behaviors occur in a systematic way and progress through several steps and decisions along a continuum. It "focuses on the identification of thinking errors that lead to and support continuation of sexual offending behaviors, increased understanding of the role of sexual arousal in sexual offending, management of addictive qualities, identification and interruption of the offense cycle, and the development of internal mastery and control" (p. 138).

Treatment module six, Empathy and Restorative Justice, depends on the affective work already completed by youth. The module first seeks to help youth continue the journey of controlling personal behaviors by linking offensive behaviors with feelings, and second, it focuses on developing and implementing a restorative justice plan. The final treatment module, Relapse Prevention and Reintegration, reflects on the addictive nature of sexual offending behaviors and stresses the continuous process of recovery and helps youth develop a plan to cope after treatment.

Calley, N. G. (2007). Integrating theory and research: The development of a research-based treatment program for juvenile male sex offenders. *Journal of Counseling & Development, 85*(2), 131-142.

### Comparing Treatment Needs of Juvenile Sexual Offenders and Nonsexual Offenders

Extremely limited controlled or comparative studies exist that examine characteristics of juvenile sexual offenders. Yet when youth are arrested for sexual offenses, they usually receive specialized treatment services based on assumptions that their psychosocial characteristics somehow differ from other juvenile offenders. This study intended to fill research gaps by implementing a rigorous comparative study to examine characteristics and contextual social relationships between multiple groups of offending and nonoffending juveniles.

Participants in the study included 115 males, ages 10 to 17, and their parents. Youth participants were divided into five equal-sized groups: sexual offenders with peer or adult victims (PS), sexual offenders with child victims (CS), violent nonsexual offenders (VN), nonviolent nonsexual offenders (NN), and nondelinquent youths (ND). All the offender youth were drawn from a sample of 599 adjudicated delinquent youth involved in the Missouri Delinquency Project. The ND youth were drawn from the same community as the offenders but had no arrest records or history of inpatient psychiatric treatment. A specified set of criteria was used to match youth across groups. No differences were found between groups on background variables except that ND youth had no history of being abused. Youth and their parents completed a battery of self-report instruments and behavior rating inventories and participated in a video-taped interaction task. Randomly selected teachers of the youth completed a rating measure on their students. Using planned group comparisons, the researchers compared and analyzed individual adjustment, family and peer relations, and academic performance for youth across groups.

The results indicated that juvenile sexual offenders have similar problems to juvenile nonsexual offenders. Both groups of offenders exhibited more family- and peer-relational problems, lower bonding to family and schools, and higher involvement with deviant peers compared with nondelinquent youth. Offender groups also had similar patterns of criminal behavior. The authors concluded that the results of this study suggest the need to move beyond specialized treatment for juvenile sexual offenders and include a focus on the multiple factors associated with sexual offending. That is, treatment should address behavior problems, family and peer relations, and academic performance.

Ronis, S. T., & Borduin, C. M. (2007). Individual, family, peer, and academic characteristics of male juvenile sexual offenders. *Journal of Abnormal Psychology, 35*(2), 153-163.

### Nonfatal Maltreatment of Infants

(Vincent J. Palusci, MD, MS, 4/9/2008)

A recent review of substantiated child maltreatment reports among infants in the National Child Abuse and Neglect Data System (NCANDS) was recently released by the U.S. Centers for Disease Control and Prevention concurrent with the release of *Child Maltreatment 2006* during Child Abuse Prevention Month. While other studies using NCANDS have looked at infants (Palusci, Smith, & Paneth, 2005), this report is described as the first published national analysis of substantiated nonfatal maltreatment of infants using NCANDS data. A total of 91,278 infants were identified as victims at a rate of 23.2 children per 1,000 population aged <1 year. These rates appear to be similar to data published for Canada. Neglect was the most common form of maltreatment (68.5%) followed by physical abuse (13.2%). NCANDS is a national data collection and analysis system created in response to the Child Abuse Prevention and Treatment Act, and data has been collected since 1993. The National Data Archive on Child Abuse and Neglect collects the data from U.S. states under supervision from the U.S. Administration for Children and Families. Although NCANDS contains information from almost all U.S. states, the data are affected by lack of more detailed information about maltreatment circumstances and variability across U.S. states in reporting and data collection practices.

The report notes that during the first year of life, there was a concentration of neglect among children in the first few days of life with a preponderance of reports from medical professionals. Many of these reports appear to be related to the time of birth, but further research was suggested regarding potential linkages to maternal or neonatal drug exposure and the best strategies for prevention. In an accompanying commentary, the authors recommended efforts to reduce shaken baby syndrome (SBS) and abusive head trauma through in-hospital programs aimed at parents of newborns. The CDC is also supporting research to evaluate replicability of these programs in diverse settings. In addition, home visitation and parent-training programs, particularly beginning during pregnancy with social support and teaching parents about developmentally appropriate infant behavior and age-appropriate disciplinary communication skills, were also recommended.

Brodowski, M. L., Nolan, C. M., Gaudiosi, J. A., Yuan, Y. Y., Ortiz, M. A., Aveni, M. M., Leeb, R. T., & Hammond, W. R. (2008). Nonfatal maltreatment of infants: United States, October, 2005–September 2006. *Mortality and Morbidity Weekly, 57*(13), 336-339.

Notes to this article:

Palusci, V. J., Smith, E. G., & Paneth, N. (2005). Predicting and responding to physical abuse in young children using NCANDS. *Children and Youth Services Review, 27*, 667-682.

MMWR: [www.cdc.gov/mmwr/preview/mmwrhtml/mm5713a2.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5713a2.htm)

*Child Maltreatment 2006*: <http://www.acf.dhhs.gov/programs/cb/pubs/cn06/index.htm>

### About the Authors

Tamara S. Davis, PhD, is Assistant Professor in the College of Social Work at The Ohio State University, Columbus, Ohio.

Beth Ann Rodriguez, MSW, is a Training Coordinator with the Institute for Human Services in Columbus, Ohio.

## Washington Update

### Thomas L. Birch, JD

### National Child Abuse Coalition

#### House and Senate Propose Discretionary Spending Increase

Just before leaving for 2 weeks of spring recess in mid-March, the House and Senate each adopted versions of a \$3 trillion congressional budget resolution for Fiscal Year 2009. These measures provide guidelines for setting funding priorities later this year in the appropriations bills, and they tag the overall amount of money the twelve appropriations subcommittees in each chamber will have to allocate to individual programs under their jurisdiction.

The Senate spending plan would provide \$18 billion more than the President proposed for discretionary funds, and the House would allow for \$22 billion more, setting the stage for a reprise of the budget battle fought last year between legislators and the President. Until Democratic leaders in Congress relented in December and agreed to meet the President's budget total for 2008, Congress had insisted on a spending bill for the current fiscal year with some \$22 billion more in discretionary funding than Bush would tolerate.

Both the House and Senate versions of the budget resolution would increase discretionary spending by almost \$2 billion above the 2008 level for social services in the Department of Health and Human Services, the Department of Education, and the Department of Labor. One of the priorities highlighted by the House and Senate FY09 spending plans is an increased allocation for the State Children's Health Program (SCHIP), rejecting the President's proposed funding of \$19.7 billion over the next 5 years for SCHIP. That funding level is deemed inadequate to provide sufficient dollars to cover even the children currently enrolled in SCHIP. The congressional budget proposal would give \$50 billion in new funds to expand coverage to six million children now eligible but not enrolled in SCHIP or Medicaid, and it would maintain coverage for all children who are currently enrolled.

Other programs with priority attention in the budget resolutions include the following: Community Health Centers at \$2.9 billion,



\$756 million above the 2008 level and \$798 million more than the President's request; National Institutes of Health at \$30 billion, \$400 million more than this year and \$950 million over the President's level; Supplemental Nutrition Program for Women, Infants, and Children (WIC) at \$6.5 billion, providing an increase of \$784 million and \$400 million above the President's mark; and Child Care Development Block Grant at \$2.5 billion in 2009, \$406 million more than in 2008 and \$441 million more than the President's request. These budget amounts offer a preview of the spending that appropriators might decide upon later in the year as the money bills move through Congress.

While the resolutions are similar in terms of their spending priorities, they differ on a few major points, such as the total amount of discretionary spending across all federal agencies. Differences between the two measures need to be worked out by a conference committee as Congress now moves toward the drafting of its appropriations bills. The biggest sticking point in the negotiations will be whether or not to offset the revenue lost from a one-year fix, estimated at \$70 billion, on the Alternative Minimum Tax (AMT), which has reached beyond the very rich for whom it was intended to apply to many middle income taxpayers.

Given the political differences between Republicans and Democrats over how to pay for the tax fix, a final agreement on a budget resolution for FY 2009 is unlikely. The House-passed measure includes instructions insisted upon by fiscally conservative Democrats to retain a "revenue-neutral" fix on the AMT issue. When this same battle was fought last December, the Senate's Republican minority prevailed over the Democrats, and the House lost. There is little reason to expect a different outcome this time. House leaders may decide that hanging onto their fiscally responsible position on taxation issues is more important than coming to agreement with the Senate on a budget resolution.

Meanwhile, the budget President Bush sent to Congress in February sets a base from which funding decisions will be made as the appropriations bills take shape. The administration's \$3.1 trillion budget proposal for fiscal year 2009 would freeze spending on most domestic discretionary programs at the current levels set in the 2008 fiscal year appropriations, including funds for most programs serving the welfare of children and families, and it would cut domestic expenditures next year by a total of \$23 billion. At the same time, the budget provides nearly 8% more in spending for defense, and homeland security would see its budget increase by nearly 20%.

The President's fiscal 2009 budget request continues toward the goal of a balanced budget by 2012. To get there, Congress would have to slash spending in several areas. The Bush budget document points to the Department of Health and Human Services' (HHS) programs as prime candidates. To begin the process, the overall budget for HHS would take a cut of 2.4% in the Bush plan for FY09.

**Child Abuse and Neglect:** Funds for the Child Abuse Prevention and Treatment Act (CAPTA) would be held at \$26.535 million for grants to states for improving protective services, at \$41.689 million for community-based child abuse prevention grants, and at \$37.135 million for discretionary grants in research and program innovation. For a second year, the discretionary grants include \$10 million for a Home Visitation Initiative, “for competitive grants that encourage states to use existing funding sources to implement and sustain proven effective, home visitation programs.” Congress last year rejected the Bush administration’s request in the FY08 budget proposal to limit the home visitation funding to nurse home visitors, preferring to fund a range of home visitation models.

**Social Services Block Grant:** The President’s budget proposes a cut of \$500 million in funding for FY 2009, toward a Bush administration plan “to eliminate SSBG funding beginning in FY 2010. This proposal interacts with several programs (TANF, Foster Care/Adoption Assistance, and the Child Care Entitlement),” the budget narrative explained, “causing their outlay rates to increase compared to current law levels.” In other words, since states that are strapped for funding to serve children and families—supplied with the inadequate appropriations available through TANF, Title IV-E foster care and adoption subsidies, and child care funds—often transfer Title XX funds into these programs to pay for needed services, the Bush administration proposes phasing out the Title XX funds altogether!

**CDC/Injury Prevention and Control:** The child maltreatment prevention activities funded by the Centers for Disease Control (CDC) would receive a slight reduction in the President’s budget at \$7.056 million, reflecting \$30,000 below the FY08 level, largely an administrative reduction. According to the budget documents prepared by CDC, its work aims to “develop, evaluate and disseminate evidence-based strategies that support and promote safe, stable, nurturing relationships with parents and other adults to prevent child maltreatment and achieve measurable and lasting positive impacts on health over the life course.”

**Community Services Block Grant:** As in past years, the Bush administration’s budget would eliminate the \$654 million Community Services Block Grant, a cut that Congress has not accepted. The grants go to antipoverty programs across the nation to provide a wide range of services and activities to alleviate the causes of poverty in communities by empowering low-income individuals and families with the resources and skills they need to become more self-sufficient and self-reliant, to achieve economic self-sufficiency and break the cycle of poverty.

**Abstinence Education:** Again, the President’s budget requests increased funding for abstinence education, from \$109 million to \$137 million, the same amount requested from and rejected by Congress last year.

The budget proposed by President Bush challenges the Democratic majority in Congress to identify its own spending priorities and, conceivably, to re-enact the budget politics played out in late 2007, where the President threatened to veto spending bills that might exceed his spending totals. Since the President is in his final year in office, Democratic party leaders might choose to take up a

continuing resolution at the end of this year’s legislative session to carry funding over until January. This would keep alive the hope of a Democrat taking office as President next year who will be more accepting of their budget priorities.

The President’s budget message reiterated his State of the Union pledge to “take steps to advance earmark reform,” and he promised to “call on the Congress to adopt the legislative line-item veto” as additional steps to address discretionary spending. Like last year, the budget debate has served as a platform for Republicans and Democrats to continue fighting over earmarks. Republicans would like to force a moratorium on earmarks until the process can be revised, and the House Democratic leaders appear poised to consider a ban on earmarks to avoid election-year criticism from Republicans. In fact, House Speaker Nancy Pelosi (D-CA) has also indicated her interest in imposing a moratorium on appropriations earmarks as a way of allowing Democrats to demonstrate fiscal responsibility.



© HARRY FIN/ DREAMSTIMES.COM

In the FY08 appropriations bill for the Department of Health and Human Services, Democrats and Republicans alike, in the House and Senate, included over \$1.8 million in earmarked appropriations for funds authorized by the Child Abuse Prevention and Treatment Act (CAPTA) to support local programs in several states. These range in size from \$87,000 to \$412,000. In addition, social services earmarks in the HHS appropriations bill (which totals some \$15 million) include over \$6.2 million to fund programs serving abused children and their families, domestic violence victims, and other family support efforts.

Cont’d on page 24

### House Hearing Focuses on Child Welfare Reform

A hearing on February 27 before the House Ways and Means Subcommittee on Income Security and Family Support drew strong endorsements for changes in federal child welfare financing laws in order to provide states with increased funds for services to prevent child maltreatment. Rep. Jim McDermott (D-WA), subcommittee chair, opened the hearing on improving the child welfare system with a call for “a new vision to ensure the protection, permanency and well-being of America’s most vulnerable children.”

In response to McDermott’s opening statement, witnesses at the hearing, one after the other, appealed to Congress to direct federal support to the prevention of child maltreatment. Seattle’s Chief of Police, Gil Kerlikowske, testifying for Fight Crime: Invest in Kids, told the subcommittee, “Prevention must be the focus of child welfare reform.”

Ken Deibert, Deputy Director of Children, Youth and Families in Arizona, appearing on behalf of the American Public Human Services Association, went even further. “A long-standing concern of state and local child welfare administrators has been the lack of flexibility in the current funding structure for child welfare services,” he told the legislators. “Title IV-E of the Social Security Act, the primary federal funding source for foster care, imposes a perverse incentive on states to remove children from their families.” Urging flexibility to allow states to use Title IV-E funds for prevention services, Deibert expanded: “We believe the funding system should reward states for reducing the number of children entering foster care, not punish them, as does the current funding system.”

McDermott has introduced H.R. 5466, The Investment in Kids Act, which seeks to reform aspects of the child welfare system to

- provide additional funding to help states to strengthen families and protect vulnerable children,
- make all foster children eligible for assistance by removing the eligibility requirement based on family income,
- provide assistance to states to improve and retain their child welfare workforce,
- extend support for children in foster care from age 18 to the age of 21, and
- provide financial support to grandparents and other relatives who care for foster children.

McDermott’s bill embodies several provisions in a child welfare financing reform proposal developed by a partnership of organizations, including representation from the National Child Abuse Coalition. However, the partnership proposal goes further than H.R. 5466 by incorporating provisions to allow states to direct the unused portion of their annual allotment of Title IV-E foster care and adoption subsidy dollars to support the full range of services necessary to prevent child abuse and neglect.

H.R. 5466 stops at offering states an option to choose to fund “a child and family services component” to be used to (1) safely reduce the number of children in foster care; (2) safely reduce the length of stay for children in foster care; and (3) increase the percentage of foster children who are cared for in family-like settings.

As MaryLee Allen, representing the Children’s Defense Fund, pointed out in her testimony, the partnership proposal would “promote investments in prevention and treatment services by redirecting for these purposes those funds that states now lose when they safely reduce their foster care caseloads and expenditures.”

McDermott intends to schedule additional hearings in the coming months “to keep attention focused on the need for Congress to exert its responsibility to protect abused and neglected children.” He called H.R. 5466 “the first step to a vision and developing consensus.” He said that he will engage subcommittee members to find common ground, and he may offer individual bills to achieve “meaningful, incremental change” and “to speed action in several critical areas” yet to be identified.

### Congress Passes Newborn Screening Bill

On April 8, the House of Representatives by voice vote passed S. 1858, the Newborn Screening Saves Lives Act, legislation introduced by Sen. Christopher Dodd (D-CT) and aimed at ensuring that every baby born in the United States will be tested for a full range of genetic and metabolic disorders. The Senate bill was co-sponsored by Sen. Orrin Hatch (R-UT).

The measure, which passed the Senate in December, was sent to the President for his signature. It includes provisions to educate parents and health care providers about the importance of newborn screening, to improve follow-up care for infants with an illness detected through screening, and to help states expand and improve their newborn screening programs.

Health screenings for newborns currently vary widely from state to state with regard to the number and types of conditions tested. According to the National Newborn Screening and Genetics Resources Center, some states test for as few as four disorders, and others test for 30 or more. The bill promotes more uniform screening procedures and allows states the resources to expand their screening programs to reach more children. Each year an estimated 4,000 babies are identified and treated for conditions that could threaten their lives or health, often preventing death and long-term disability.

### About the Author

Since 1981, Thomas Birch, JD, has served as legislative counsel in Washington, D.C., to a variety of nonprofit organizations, including the National Child Abuse Coalition, designing advocacy programs, directing advocacy efforts to influence congressional action, and advising state and local groups in advocacy and lobbying strategies. Birch has authored numerous articles on legislative advocacy and topics of public policy, particularly in his area of specialization in child welfare, human services, and cultural affairs.

### APSAC Publishes New Practice Guidelines

The American Professional Society on the Abuse of Children recently published *Challenges in the Evaluation of Child Neglect*. It is the most recent in the organization's Practice Guidelines series. More than 200 copies of the document have already been distributed.

Developed by an APSAC task force, the document was published "...to give a broad overview of the current understanding of child neglect, using an evidence-based approach to focus on the impact of neglect on children, and the multidisciplinary approach to child neglect evaluations." It does not address specific intervention strategies.

Subjects covered by this Guideline volume include the following:

- Definition
- Classification
- Identification
- Etiology
- Risk and Harm in Child Neglect
- Neglect Associated With Caretaker Drug Abuse
- Assessment/Investigation of Neglect

Several templates and datasheets are also provided in the Appendix section.

*Challenges in the Evaluation of Child Neglect* is available for purchase from APSAC. The price per copy is \$5 for members and \$10 for nonmembers, plus shipping and handling. You can order online by visiting Publications, Practice Guidelines at [www.apsac.org](http://www.apsac.org). A downloadable PDF order form is also available.



### APSAC Supports Amicus Brief for Child Witness Issues

Dr. Michael Haney, president of APSAC, announced that the organization is supporting the State of California in an amicus brief before the Supreme Court of the United States. The National Association of Counsel for Children also supports the brief. The case deals with child witness issues and how the courts assess hearsay. The following is a summary of the 48-page brief:

The National Association of Counsel for Children and the American Professional Society on the Abuse of Children submitted *amicus* briefing to the United States Supreme Court in *Giles v. California*. In *Giles*, the Court is set to further define the contours of a criminal defendant's right to confront witnesses under the Sixth Amendment of the Constitution. The Giles case will determine when a defendant's wrongful behavior causes that right to be forfeited.

In *Giles*, the California trial court, Court of Appeal, and Supreme Court all held that the defendant had lost his right to cross-examine statements made by his wife when the defendant killed her. The prosecution then admitted statements of the defendant's deceased wife, and Giles was convicted. The defendant, however, petitioned the U.S. Supreme Court on the grounds that, since he did not kill his wife with the specific intent of affecting her ability to later attend trial as a witness, he should not have been held to have forfeited his constitutional right of cross-examination. The Supreme Court accepted the case and is now set to decide whether defendants must specifically intend to affect a witness's attendance at trial before confrontation rights are forfeited.

The NACC and APSAC briefed the Supreme Court on the historical and modern implications of this issue on the rights of child victims. Our briefing illustrated support for a constitutional standard that accounts for the public interest in protecting children from abuse and in prosecuting their abusers. The brief provided an extensive look into how eighteenth-century courts admitted the hearsay of child victims. The brief then contrasted this historical perspective with the way modern courts have excluded similar evidence in implementing Supreme Court's historically-based confrontation doctrine. The brief urged the Court to acknowledge the historical precedent and recognize that there is no constitutional basis for the Sixth Amendment to require the exclusion of hearsay in cases where abusers have acted in the face of the predictable unavailability of vulnerable or very young witnesses.

Irell and Manella collaborated on the brief with attorneys from Jenner & Block LLP and University of Southern California Law Professor Thomas D. Lyon, JD, PhD, as well as a research team University of Southern California law students. The Court heard the matter on April 22, 2008.

A complete copy (PDF format) of the brief is available in the News section of the APSAC Web site under the Resources tab. More detailed information can also be accessed at [http://www.jenner.com/news/news\\_item.asp?id=14589924](http://www.jenner.com/news/news_item.asp?id=14589924).

Cont'd on page 26

## NEWS OF THE ORGANIZATION

### AP SAC's Child Forensic Interview Clinic Does Well in Virginia Beach

Thirty-one attendees took part in the recent Child Forensic Interview Clinic that was held March 10–14 in Virginia Beach, Virginia. Participants came from 14 states and Canada and represented a wide variety of disciplines, including child interviewers, social work/CPGS, law enforcement, community caregivers, victim advocates, CPT case coordinators, and more.

In addition to providing an excellent opportunity for education, the clinic served as a means of member recruitment, with eight new members joining APSAC as a result of their participation in the Clinic.

Consistent with its mission, APSAC pioneered the Forensic Interview Training Clinic model to focus on the needs of professionals responsible for conducting investigative interviews with children in suspected abuse cases. Interviews with children have received intense scrutiny in recent years and increasingly require specialized training and expertise. This comprehensive Clinic offers a unique opportunity to participate in an intensive 40-hour training experience and to have personal interaction with leading experts in the field of child forensic interviewing. Developed by top national experts, APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing, which offers a balanced review of several models.

Topics include the following:

- How investigative interviews differ from therapeutic interviews.
- Overview of various interview models and introduction to forensic interview methods and techniques.
- Child development considerations and linguistic issues.
- Cultural considerations in interviewing.
- Techniques for interviewing adolescents, reluctant children, and children with disabilities.
- Being an effective witness.

APSAC's next Child Forensic Interview Clinic is scheduled for June 2–6 in Seattle, Washington. Thirty-five people are already registered to attend. Details and registration materials are available on the APSAC Web site, [www.apsac.org](http://www.apsac.org).

### APSAC Web Site...A Tool Designed for the Community

APSAC provides an ever-growing list of resources and information on its Web site, from event listings and online registration to news, publications, and a searchable Membership Directory.

The site is currently divided into several tabs or sections:

- *Welcome to APSAC* – the home page, complete with the latest announcements.
- *About Us* – includes Board of Directors, state chapters, contact and donation information, and APSAC awards.
- *Membership* – describes membership and benefits, and provides online access to becoming a member.
- *Events and Meetings* – provides access to events sponsored

by APSAC and others, and offers registration materials for APSAC meetings and conferences.

- *Publications* – descriptive information on various APSAC publications and ordering information (online and PDF form).
- *Resources* – provides links to a variety of organizations and information relevant to the organization and its purpose. Also includes a growing News section on APSAC and its members.
- *Members Only* (must be logged-in to view) – includes the APSAC directory and both simple and advanced search capability for locating colleagues. You can also update your membership profile, renew your membership, and find instructions for accessing the online version of the APSAC journal, *Child Maltreatment*.

APSAC's Board of Directors is currently looking at several new initiatives for the Web. These include the following:

- E-list or listserv so that members can communicate via E-mail with subscribed member colleagues.
- A fully functional Career Center, where resumes can be posted at no cost and organizations can advertise job openings.
- Publication archiving that would include access to articles from both current and back issues of the *APSAC Advisor*.

If you are an APSAC member, you are encouraged to log-in and become familiar with the Web site (contact APSAC headquarters if you don't have your unique log-in information). And be sure to check back frequently for updates, announcements, and new resources.

### APSAC Committees in Full Gear

Over the past few months, many of APSAC's committees have been active via conference call as they work to develop the organization's future. Recently, the Education, Diversity, State Chapter, Executive, Publication, and Award committees have held meetings. Each APSAC committee plays a vital role in APSAC services and governance. These volunteer groups, who work with and report to the Board of Directors, are responsible for recent publications, programming content, local meetings, recognition, and much more.

If you have an interest in serving APSAC as a committee member, please contact our office in Elmhurst, Illinois.

**The next issue of the *APSAC Advisor*  
will be a special double issue, coming  
out in the fall. Watch for it!**

## CONFERENCE CALENDAR

**July 16–18, 2008**

**5th Annual Multidisciplinary Conference on Child Abuse**  
Orlando, FL

Visit: [www.FNCAC.org](http://www.FNCAC.org), or E-mail: [fncac@embarqmail.com](mailto:fncac@embarqmail.com)

**July 16–20, 2008**

**Training Institutes 2008 "Developing Local Systems of Care for Children and Adolescents with Mental Health Needs and Their Families"**

Nashville, TN

Call: 202.687.5000, or Visit: <http://gucchd.georgetown.edu>,  
or E-mail: [Institutes2008@aol.com](mailto:Institutes2008@aol.com)

**July 27–29, 2008**

**International Family Violence and Child Victimization Research Conference**

Portsmouth, NH

Visit: [www.unh.edu/frl/conferences/2008](http://www.unh.edu/frl/conferences/2008), or  
E-mail: [frl.conference@unh.edu](mailto:frl.conference@unh.edu)

**July 31–August 2, 2008**

**34th North American Council on Adoptable Children (NACAC) Conference**

Ottawa, ON, Canada

Call: 651.644.3036, or Visit: [www.nacac.org](http://www.nacac.org), or  
E-mail: [info@nacac.org](mailto:info@nacac.org)

**August 3–6, 2008**

**NACC 31st National Juvenile and Family Law Conference**

Savannah, GA

Call: 888.828.NACC, or Visit: [www.naccchildlaw.org](http://www.naccchildlaw.org), or  
E-mail: [advocate@naccchildlaw.org](mailto:advocate@naccchildlaw.org)

**August 11–14, 2008**

**Crimes Against Children Conference**

Dallas, TX

Visit: [www.cacconference.org](http://www.cacconference.org), or  
E-mail: [conference@dcac.org](mailto:conference@dcac.org)

**September 4–5, 2008**

**2008 Family Court Conference: Faces Behind the Cases**

Orlando, FL

Visit: [www.flcourts.org/gen\\_public/family/08conference.shtml](http://www.flcourts.org/gen_public/family/08conference.shtml), or E-mail: [gandyk@flcourts.org](mailto:gandyk@flcourts.org)

**September 7–10 2008**

**IPSCAN International Congress on Child Abuse and Neglect**

Hong Kong SAR, China

Visit: [www.ipscan.org/congress2008](http://www.ipscan.org/congress2008), or  
E-mail: [congress2008@ipscan.org](mailto:congress2008@ipscan.org)

**September 21–24, 2008**

**21st Annual Professional Development Conference National Staff Development and Training Association (NSDTA)**

Atlanta, GA

Call: 202.682.0100, or Visit: <http://nspta-atlanta.org>

**October 5–8, 2008**

**7th North American Conference on Shaken Baby Syndrome**

Vancouver, BC, Canada

Visit: [www.dontshake.org](http://www.dontshake.org), or E-mail: [btasker@dontshake.org](mailto:btasker@dontshake.org)

**November 12–14, 2008**

**8th National Structured Decision Making® Conference Children's Research Center/ California Dept. Social Services**

Sacramento, CA

Visit: [www.nccd-cre.org/c\\_conference\\_main.html](http://www.nccd-cre.org/c_conference_main.html), or  
E-mail: [anoel@mw.nccd-crc.org](mailto:anoel@mw.nccd-crc.org)

**November 16–19, 2008 and May, 2009**

**2008 PREVENT Child Maltreatment Institute**  
Chapel Hill, NC

Visit: <http://prevent.unc.edu/education>, or  
E-mail: [PREVENT@unc.edu](mailto:PREVENT@unc.edu)



# AP SAC ADVISOR

## EDITOR IN CHIEF

Ronald C. Hughes, PhD, MScSA  
Institute for Human Services and  
the North American Resource Center  
for Child Welfare, 1706 E. Broad Street  
Columbus, OH 43203  
614.251.6000

## ASSOCIATE EDITOR

Judith S. Rycus, PhD, MSW  
Institute for Human Services and  
the North American Resource Center  
for Child Welfare

## EDITORIAL ASSISTANT

Susan C. Yingling  
Institute for Human Services and  
the North American Resource Center  
for Child Welfare

## CONSULTING EDITORS

### Child Protective Services

Maria Scannapieco, PhD  
University of Texas at Arlington  
School of SW Center for Child Welfare,  
Arlington, TX 817.272.3535

### Cultural Issues

Michael de Arellano, PhD  
National Crime Victims Research and  
Treatment Center Medical  
University of South Carolina  
Charleston, SC 843.792.2945

### Education

Irene R. Berson, PhD, NCSP  
Early Childhood Education  
College of Education  
Tampa, FL 813.974.7698

### Journal Highlights

Tamara Davis, PhD  
College of Social Work,  
The Ohio State University  
Columbus, OH 614.247.5025

### Law

Thomas Lyon, JD, PhD  
University of Southern California  
Law Center  
Los Angeles, CA 213.740.0142

### Medicine

Lori Frasier, MD  
Primary Children's Medical Center  
Salt Lake City, UT 801.588.3650

### Mental Health/Perpetrators

Steven L. Ondersma, PhD  
Wayne State University  
Merrill-Palmer Institute  
Detroit, MI 313.872.1790

### Nursing

Beatrice Yorker, RN, JD  
California State University  
College of Health and Human Services  
Los Angeles, CA 323.343.4739

### Washington Update

Thomas Birch, JD  
National Child Abuse Council  
Washington, DC 202.347.3666

### Prevention

Neil B. Guterman, PhD  
Columbia University  
School of Social Work  
New York, NY 212.854.5371

### Research

David Finkelhor, PhD  
University of New Hampshire Family  
Research Laboratory  
Durham, NH 603.862.2761

Opinions expressed in the APSAC Advisor do not reflect  
APSAC's official position unless otherwise stated. Membership  
in APSAC in no way constitutes an endorsement by APSAC  
of any member's level of expertise or scope of professional  
competence. ©APSAC 2008

## APSAC Important Contact Information

350 Poplar Avenue, Elmhurst, Illinois 60126  
Toll free: 877.402.7722, and 630.941.1235  
Fax: 630.359.4274 E-mail: [apsac@apsac.org](mailto:apsac@apsac.org)  
Web site: [www.apsac.org](http://www.apsac.org)



American Professional Society  
on the Abuse of Children

350 Poplar Ave.  
Elmhurst, IL 60126

Non-Profit Organization  
US POSTAGE  
PAID  
Eau Claire, WI  
Permit No. 2066