



## Complete Summary

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### GUIDELINE TITLE

Practice parameters for the assessment and treatment of children and adolescents who are sexually abusive of others.

### BIBLIOGRAPHIC SOURCE(S)

American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents who are sexually abusive of others. American Academy of Child and Adolescent Psychiatry Working Group on Quality Issues. J Am Acad Child Adolesc Psychiatry 1999 Dec; 38(12 Suppl): 32S-54S. [145 references]

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

Sexually abusive behavior

### GUIDELINE CATEGORY

Diagnosis  
Evaluation  
Treatment

### CLINICAL SPECIALTY

Psychiatry

### INTENDED USERS

Physicians

## GUIDELINE OBJECTIVE(S)

- To summarize current knowledge about the epidemiology and phenomenology of sexually abusive youth.
- To provide guidelines for the assessment and selection of treatment interventions for sexually abusive youth.

## TARGET POPULATION

Children and adolescents who are sexually abusive of others

## INTERVENTIONS AND PRACTICES CONSIDERED

### Diagnosis

1. Clinical interview, to assess:
  - Sexual-aggressive history
  - Developmental and psychosocial history
  - Medical and psychiatric history
  - School history
  - Mental status examination
2. Psychological tests
3. Phallometric assessment
4. Disposition

### Treatment

1. Cognitive-behavioral interventions:
  - Specific educational modules such as victim awareness/empathy, cognitive restructuring; anger management; assertiveness training; social skills training; sexual education; stress reduction and relaxation management; and autobiographical awareness
  - Specific behavioral techniques to diminish deviant sexual arousal, including covert sensitization; assisted covert sensitization; imaginal desensitization; olfactory conditioning; satiation techniques; and sexual arousal reconditioning
  - Relapse prevention
2. Psychosocial therapies, including traditional individual approaches, family therapy, group therapies, and the use of the therapeutic community.
3. Psychopharmacological interventions including selective serotonin reuptake inhibitors; antiandrogen medication in selected cases.

## MAJOR OUTCOMES CONSIDERED

Not stated

## METHODOLOGY

## METHODS USED TO COLLECT/SELECT EVIDENCE

## Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A computer literature search based on Medline and Psychological Abstracts using key words such as child, adolescent, juvenile, sex, sexual, abuse, abuser, offenses and offender was obtained. References included major review articles, book chapters and monographs as well as journals with a specific focus on sexual abusive behaviors. Additionally the authors and consultants contributed from their own cumulative clinical and professional experiences.

### NUMBER OF SOURCE DOCUMENTS

Not stated

### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not stated

### METHODS USED TO ANALYZE THE EVIDENCE

Review

### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

### DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Clinical consensus was determined through extensive review by the members of the Work Group on Quality Issues, child and adolescent psychiatry consultants with expertise in the content area, the entire Academy membership, and the Academy Assembly and Council.

### RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

### COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Four individuals are acknowledged by name for reviewing the practice parameter. These parameters were made available to the entire Academy membership for review in September, 1998 and were approved by the Academy Council on June 27, 1999.

# RECOMMENDATIONS

## MAJOR RECOMMENDATIONS

### The Evaluation Process

The evaluation and treatment of children and adolescents with sexually abusive behavior require an understanding of the biological and psychosocial factors determining the child's sexual development, gender role, sexual orientation, patterns of sexual arousal, sexual cognitions, sexual socialization and the integration of sexual and aggressive patterns of behavior. The individual's sexuality evolves in concert and as a result of interaction with family, ethnic, social and cultural influences.

The clinical assessment of juvenile sexual abusers requires the same comprehensive evaluation as other children and adolescents. Important sources of information include medical and psychological reports, offense reports, victim statements, protective services reports, and probation reports. The collateral information should be obtained before the individual interview; otherwise one is left relatively unprepared before the offender's normal proclivity to minimize and deny.

### Forensic Considerations

It is essential that the clinician define his role in the assessment of the sexual abuser. While many of the issues are relevant to a forensic evaluation, these parameters are designed to provide guidelines for the clinical evaluation of the sexual abuser. It is generally preferable to conduct the clinical evaluation after adjudication. The focus of the clinical interview is on assessing amenability to treatment, required levels of care, treatment goals and objectives and the risk of reoffending. The juvenile sex abuser is advised of reporting laws and the limits of professional confidentiality. An informed consent signed by the juvenile and his parent/guardian should be obtained prior to the clinical interview. It is important to educate and clarify for the individual and his family what is going to happen and when. The role of protective services and the juvenile justice system should be explained when relevant. Consent forms should be developed to cover the use of controversial assessment and treatment procedures such as phallometric

assessment, aversive conditioning, and medications that are not accepted as standard of practice.

### The Clinical Interview

The clinical interview is the cornerstone of the evaluation of juvenile sexual abusers. It is necessary to establish the nature of the sexually abusive behavior. Since laws have frequently been transgressed the offender is often less than forthcoming. Issues of shame, guilt and fear of punishment impede disclosure. The clinician is advised to adopt a nonjudgmental stance and to relate to the juvenile offender in a matter-of-fact exploratory manner. The clinician clarifies the meaning of sexual jargon and avoids its use. The interview is initiated with a nonthreatening line of questioning thereby minimizing the initial defensiveness. The interviewer develops lines of questioning that will allow him/her to know more about the offender, his family, school and his current life situation. Confront minimization, denial and the apparent omissions of important information. There is little value in getting angry and accusatory. It is more useful to be patient, persistent and not easily dissuaded.

### The Assessment of the Sexually Abusive Behavior

In the evaluation the clinician develops certain lines of questioning regarding the sexual abuser and the sexual abusive incident. One wants to learn the following from the clinical interview:

- Degree of cooperation.
- Honesty and forthrightness of the abuser.
- Degree of acceptance of responsibility for his sexual offenses.
- Degree of remorse and regret.
- Relationship between the abuser and the victim.
- Age difference between the abuser and the victim.
- Characteristics of the sexual aggressive behavior.
- Frequency and duration of the sexual aggressive behavior.
- Precipitating factors that led to the sexual offense.
- Premeditated or impulsive.
- Characteristics of the victim that attracted the offender.
- Nature and extent of the coercive behaviors.
- Behaviors prior to, during and post sexual offense.
- Affect states prior to, during and post sexual offenses.
- Verbal interchange with the victim.
- Attempts to avoid detection.
- Understanding of the effects of his sexual behavior on the victim.
- Insight into the wrongfulness of his sexual behavior.
- Understanding of the consequences of his behavior.

The Sexual-Aggressive History. The clinician obtains the juvenile's sexual history and assesses his sexual knowledge and education, sexual development, and sexual experiences. Inquiries are directed to learn what the juvenile knows about gender differences, sexual intercourse, and his preferred patterns of sexual behaviors. Specific questions may be asked regarding the juvenile's understanding and knowledge of normal sexual activities, i.e., kissing, dating, petting, masturbation, whether he has been sexually active and engaged in intercourse,

homoerotic experiences, etc. Has he been exposed to inappropriate and explicit sexuality? The clinician attempts to delineate the established pattern and spectrum of previously committed sexual aggressive acts; the victim profile; the internal and external triggers that initiate the sexual abuse cycle; the role of aggression and sadism in the sexual offense; the need to dominate, control, and humiliate the victim; the erotization of the aggression; the history of sexual victimization, physical abuse, and emotional neglect; and the history of prior non-sexual delinquent behavior. It is necessary to discriminate between compulsive sexual behaviors and paraphilic compulsive sexual behaviors. Is there a history of arrests, convictions, incarcerations, use of weapons or cruelty to animals?

**Developmental and Psychosocial History.** Other areas of the assessment process are those associated with a comprehensive developmental history, i.e., the nature of the pregnancy, perinatal history, developmental milestones, family relationships, early identificatory models, capacity for relationships, peer relationships and social skills. The family assessment provides an opportunity to understand the early developmental and environmental context within which the sexual abuser developed. Information is obtained regarding the parents' personal and psychological history, their use of authority and discipline, the role of coercive sexuality in the family. How is affection, tenderness, competition, aggression, love, sexuality and lust expressed in the family? How supportive and available is the family as a treatment resource?

**Medical and Psychiatric History.** It is important to obtain a comprehensive medical and psychiatric history with specific attention to psychopathology, substance abuse and psychiatric co-morbidity.

**School History.** A specific area of concern is the evaluation of intellectual capacities, and academic performance. Fifty to 80% of juvenile sexual abusers have learning problems, repeated a grade in school, and/or have been in classes for the learning disabled.

**Mental Status Examination.** A comprehensive mental status examination is carried out to assess the presence of psychopathology, personality disturbances, organicity, and substance abuse and to acquire an understanding of adaptive, coping, and defensive strategies. Suicidal content and risk should be assessed specifically. A careful assessment of the spectrum of suicidal behavior is undertaken to establish the degree to which suicidal ideation, history of suicidal behaviors, threats or plans are present. Apprehension by judicial authority and the associated shame of exposure, embarrassment, stigmatization, fear of punishment and incarceration are risk factors for suicidal behavior.

#### Psychological Tests

There are no specific empirical measures or psychometric tests that can identify, diagnose or classify sexual abusers. Although psychological testing may be used adjunctively to understand the personality traits, sexual behaviors, and intellectual capacities of these youngsters.

#### Phallometric Assessment

Some authors have recommended the use of phallometric testing, the measuring of penile erection in response to different stimuli as a way to determine sexual preferences. This technique is usually reserved for the most severe and older juvenile sexual abusers. This procedure has generally been used with caution because of the lack of empirical studies, problems in obtaining informed consent, and a reluctance to expose children and adolescents to further sexual stimulation through the portrayal of deviant sexual activities.

## Disposition

At the end of the assessment process, the clinician should be prepared to address the following issues and to provide guidance to other professionals, the juvenile court and community agencies.

- The risk of repeating the sexually aggressive behavior
- The treatment needs of the individual and his family
- The appropriateness of removing the sexual abuser from his family
- The appropriate treatment program for the abuser, e.g. a community outpatient treatment program or a more restrictive environment, such as a detention center, residential program, or inpatient unit.

In the final stages of the evaluation, it is useful to discuss the possible treatment alternatives with the patient and appropriate family members. Explain to the family members what their participation will be in the treatment program.

## Treatment

The spectrum of emotional, behavioral and developmental problems presented by these young people requires an integrated multi-model treatment program which is tailored to the individual's clinical presentation, and social and family support system. The treatment of juvenile sexual abusers has generally focused on several objectives, which are integral to a successful intervention:

- Confronting the sex abuser's denial
- Decreasing deviant sexual arousal
- Facilitating the development of non-deviant sexual interests
- Promoting victim empathy
- Enhancing social and interpersonal skills
- Assisting with values clarification
- Clarifying cognitive distortions
- Teaching the juvenile to recognize the internal and external antecedents of sexual offending behavior with appropriate intervention strategies

The predominant treatment approaches include cognitive-behavioral, and psychosocial therapies and psychopharmacological interventions. A group setting is the preferred format in treatment programs for sexual abusers and is usually the conduit through which cognitive-behavioral modalities (such as psycho-educational, behavioral, and relapse prevention programs) are conducted.

## Cognitive-Behavioral Interventions

Psychoeducational modules provide information about sexuality, sexual deviancy, cognitive distortions, interpersonal and social behaviors, and strategies for coping with aggressive and sexual impulses. Specific educational modules may include: victim awareness/empathy; cognitive restructuring; anger management; assertiveness training; social skills training; sexual education; stress reduction and relaxation management; and autobiographical awareness.

Specific behavioral techniques that have been used to diminish deviant sexual arousal include: covert sensitization; assisted covert sensitization; imaginal desensitization; olfactory conditioning; satiation techniques; and sexual arousal reconditioning.

Relapse prevention assumes that sexual offenses are the product of contextual triggers and an array of emotional and cognitive precursors. In this intervention, the sexual abuser becomes aware of each phase of his sexual assault cycle and its unique characteristics, so that he will become knowledgeable about the triggers that initiate the cycle. The goals of relapse prevention are to empower the offender to manage his own sexual life through a cognitive understanding of the antecedents of his sexual offending behavior and the development of coping strategies with which to interrupt the sexual offending cycle.

#### Psychosocial Therapies

Psychosocial therapies include traditional individual approaches, family therapy, group therapies, and the use of the therapeutic community.

Group therapy with juvenile sex offenders provides a context in which the sexual abuser is unable to easily minimize, deny, or rationalize his sexual behaviors. Peer group therapy, as the medium for therapeutic interventions, is used in a number of different ways depending on the setting, group membership, the severity of the sexual offenses, group goals and objectives, whether the groups are open or closed, and the length of the group experience. Therapeutic community groups are often used in hospital or residential treatment settings as a vehicle for milieu administrative decision-making and for the monitoring of a behavioral management system.

Family therapy may be most useful in those instances where there is incest, especially when the sex offender remains in the family or will rejoin the nuclear family after treatment. Family therapy facilitates the learning of new ways of communicating and building a support system which will help interrupt the abuse cycle and ultimately be supportive to the offender's capacity for regulating and modulating sexual aggressive behavior. The parents should be seen for counseling or be placed in a concurrent structured parent group with an emphasis on educational modules where they can become familiar with sexual abusive behavior, risk and protective factors, characteristics of sexual abusers, treatment strategies, and most importantly focus on styles of interaction and management of their children's sexual behavior.

Individual therapy is usually employed in conjunction with other treatment approaches and probably should never be relied on as the only treatment modality. However, individual therapy may be the treatment of choice for the younger sexually-reactive abused child who has become sexually abusive. This is

particularly true for children who manifest high levels of intra psychic conflict, emotional distress, confusion, and defensiveness around their own sexual victimization.

#### Psychopharmacological Interventions

Selective serotonin reuptake inhibitors (SSRIs) have been shown to have an impact on sexual drive, arousal and sexual preoccupations. Fluoxetine has been the agent most studied and there are a number of reports indicating that its use is associated with a reduction in paraphiliac behavior and non-paraphiliac sexual obsessions.

The antiandrogen drugs are reserved for the most severe sexual abusers and are generally discouraged for use in adolescents younger than 17 years of age. Antiandrogen medications should never be used as an exclusive treatment for paraphiliac and aggressive sexual behaviors.

#### CLINICAL ALGORITHM(S)

None provided

### EVIDENCE SUPPORTING THE RECOMMENDATIONS

#### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence for each recommendation is not stated. In general, the parameters are based on evaluation of the scientific literature and relevant clinical consensus.

### BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

#### POTENTIAL BENEFITS

Effective application of strategies for patient management may assist clinicians in psychiatric decision-making and provide guidance to other professionals, the juvenile court and community agencies who handle sexually abusive children and adolescents.

#### POTENTIAL HARMS

Not stated

### QUALIFYING STATEMENTS

#### QUALIFYING STATEMENTS

Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision-making. These parameters are not intended to define the standard of care; nor should they be deemed inclusive of all proper

methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources. Given inevitable changes in scientific information and technology, these parameters will be reviewed periodically and updated when appropriate.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents who are sexually abusive of others. American Academy of Child and Adolescent Psychiatry Working Group on Quality Issues. *J Am Acad Child Adolesc Psychiatry* 1999 Dec; 38(12 Suppl): 32S-54S. [145 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

1999 Jun 27

### GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

## SOURCE(S) OF FUNDING

Not stated

## GUIDELINE COMMITTEE

Not stated

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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Work Group on Quality Issues: William Bernet, MD (Chair); John E. Dunne (former Chair); Maureen Adair, MD; Valerie Arnold, MD; Joe Beitchman, MD; R. Scott Benson, MD; Oscar Bukstein, MD; Joan Kinlan, MD; Jon McClellan, MD; David Rue, MD.

## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

As a matter of policy, some of the authors to these practice parameters are in active clinical practice and may have received income related to treatments discussed in these parameters. Some authors may be involved primarily in research or other academic endeavors and also may have received income related to treatments discussed in these parameters. To minimize the potential for these parameters to contain biased recommendations due to conflict of interest, the parameters were reviewed extensively by Work Group members, consultants, and Academy members; authors and reviewers were asked to base their recommendations on an objective evaluation of the available evidence; and authors and reviewers who believed that they might have a conflict of interest that would bias, or appear to bias, their work on these parameters were asked to notify the Academy.

## GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

## GUIDELINE AVAILABILITY

Electronic copies: Available (to members only) from the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site.](#)

Print copies: Available from AACAP, Communications Dept., 3615 Wisconsin Ave, NW, Washington, DC 20016. Additional information can be obtained through the [AACAP Publication Catalog for Parameters.](#)

## AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- American Academy of Child and Adolescent Psychiatry (AACAP). Summary of the practice parameters for the assessment and treatment of children and adolescents who are sexually abusive of others. J Am Acad Child Adolesc Psychiatry 2000 Jan; 39(1): 127-30.

Print copies: Available from AACAP, Communications Dept., 3615 Wisconsin Ave, NW, Washington, DC 20016. Additional information can be obtained through the [AACAP Publication Catalog for Parameters](#).

#### PATIENT RESOURCES

None available

#### NGC STATUS

This summary was completed by ECRI on February 28, 2000. The information was verified by the guideline developer on October 18, 2000.

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