
INTRODUCTION

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A Brief History of Treating Youth with Sexual Behavior Problems

A deep understanding of evaluating and treating sexually abusive youth requires that that we first know our history and ourselves. Many who began this work in the 1980s have since concluded that much of what we thought we knew turned out to be wrong. This introduction outlines many of the accomplishments in understanding young people who have sexually abused since the mid-20th century.

Although unfamiliar to many, Kurt Freund was a pioneer in the field of human sexuality. Living in Czechoslovakia, Freund helped to develop and research the volumetric penile plethysmograph, a device that measures penile engorgement in response to auditory and/or visual stimuli. The military used his early research to help detect homosexuals joining the ranks. While the plethysmograph often raised more questions than it answered regarding the nature of sexual arousal and interest, it was the first objective measure of its kind. It provided a common and unified area of study. Freund eventually left Czechoslovakia and settled at Clarke University in Toronto, where his research continued in many areas, ranging from the use of plethysmography with sexual abusers to the construct of “courtship disorder.”

The plethysmograph began to find use outside the research laboratory in subsequent decades, particularly following public awareness of sexual abuse as a topic of societal concern. The advent of the women’s movement (e.g. Brownmiller, 1975) certainly helped bring the issue of sexual abuse to the forefront of discussion.

One of the first documents published about the sex offender treatment movement was written by Edward Brecher (1978) and supported by a grant from the National Institute of Law Enforcement and Criminal Justice, the law enforcement assistance administration of the U.S. Department of Justice. The grant funds were awarded to the American Correctional Association under the Omnibus Crime Control and Safe Streets Act of 1968. In the abstract, Brecher notes,

“What should be done about sex offenders after they have been sentenced and turned over to the correctional system? ... Nothing in particular is being done about the vast majority of them and little or no attention is being paid to the partic-

ular factors which made these men sex offenders—and which may (or may not) lead them to commit future sex offenses. There are however, some notable exceptions. This survey report presents information on 20 treatment programs in 12 states which are directly concerned with the existing sexual problems and future of correctional inmates, probationers and parolees. Three additional programs which are no longer in operation, but have considerable historical interest are also described..." (p. v).

The programs in Brecher's monograph were identified, in part, through the help of several people, including Fay Honey Knopp, founder of the Prison Research Education Action Project of Westport, Connecticut. This evolved into the Safer Society Program of Orwell, Vermont. Robert E. Longo (published as Robert E. Freeman-Longo, between 1982 and 2001) became the director of the Safer Society Program in 1993 and transformed it in 1994 into the current Safer Society Foundation in Brandon, Vermont. Brecher goes on to say:

"The first four American programs for sex offenders were established by California in 1948, by Wisconsin in 1951, and by Massachusetts and Washington State in 1958." (p. 5)

Since Brecher's publication, the Safer Society has continued to track the existence and development of sex offender treatment programs with monographs dated from 1982 through 2002.

Many of the earliest programs cited in Brecher's monograph, as well as those that developed through the 1970s and 1980s, were created as the result of specific horrific crimes publicized at state and national levels. Several of these crimes included the abduction, rape, and murder of a child or adult woman.

Brecher's monograph identified twenty programs in twelve states. Only one program (in Seattle) treated juveniles. This clinic operated out of the School of Medicine at the University of Washington. Programs in Florida treated both adult and juvenile sexual offenders. It was at the North Florida Evaluation and Treatment Center in Gainesville, Florida that Longo and his colleagues decided to separate younger clients from the adults and develop specialized housing and programming for them (Longo & McFadin, 1981).

In 1982, Fay Honey Knopp continued to identify and explore treatment for sexually abusive youth, publishing *Remedial Intervention in Adolescent Sex Offenses: Nine Program Descriptions* (Knopp, 1982). This was the first report on adolescent sex offenders and their treatment. The nine programs consisted of five community-based and four residential treatment programs located in Washington, Minnesota, Colorado, and Washington, D.C.

Knopp's initial publication was followed by *A Preliminary Survey of Adolescent Sex Offenses in New York: Remedies and Recommendations* (Jackson, 1984), also published by the Safer Society. By 1986, the Safer Society Press had begun a journey, which continues today, of reporting on programs that treat sexual offenders (Knopp, Rosenberg, &

Stevenson, 1986). In the 1986 survey, the Safer Society Program had identified a total of 297 programs treating adult sex offenders and 346 treating juvenile sexual offenders.

The majority of programs at that time used family therapy, peer-group treatment groups, cognitive restructuring, and behavioral treatment methods. Some used penile plethysmography and aversive conditioning. Psycho-educational models were most common, and concepts such as aftercare did not exist for those youth who came out of residential treatment programs. The use of phallometry with adult sex offenders was a heated debate, and sparingly used (in 12% of the reported programs) with juveniles.

1982 saw the beginnings of the Association for the Treatment of Sexual Abusers (ATSA), now an international organization. At the Oregon State Hospital in Salem, Robert Longo began weekly brown-bag luncheon meetings to discuss issues related to the evaluation and treatment of sex offenders. This included concerns around the use and misuse of the penile plethysmograph, which was being used in some cases to determine guilt or innocence in legal settings. In one case, a local evaluator was conducting evaluations of eight hours' duration. By 1983 other professionals in community-based treatment programs outside Oregon State Hospital joined this small group of individuals.

As this group's knowledge expanded and concerns deepened, the individuals involved decided to form an organization. On December 18, 1984, they officially established the Association for the Behavioral Treatment of Sexual Aggressors (ABTSA) in Salem, Oregon. Robert Longo served as ABTSA's first President. On April 30, 1986, ABTSA filed its new name, The Association for the Behavioral Treatment of Sexual Abusers, and it was several years later that the name was changed to its current name, The Association for the Treatment of Sexual Abusers (ATSA).

ATSA began as a state organization focused on the assessment and treatment of adult sexual offenders. It wasn't until the late 1980s that ATSA began to spread its scope to include juvenile sexual abusers. Today it also addresses issues related to sexually reactive children. In February 1986, the 5th Annual Conference on Sexual Aggression, sponsored by the National Institute of Mental Health and Florida Mental Health Institute, was held in Tampa, Florida. This would be the last in the series of national meetings funded under grants from the National Institute of Mental Health (NIMH) held by Dr. Gene Abel (in cooperation with Dr. Judith Becker), and later, Dr. D. Richard Laws.

After this meeting, Robert Longo contacted Dr. James Brieling with NIMH to see whether the annual Research and Treatment conference could be continued if funding were found. It was from this collaboration that ATSA's successful annual conferences emerged, first organized by Robert Longo and several ABTSA Board members, including Jim Haaven, and Jan Hindman. In May 1987, the 6th Annual Conference on Sexual Aggression: Assessment & Treatment, Association for the Behavioral Treatment of Sexual Abusers took place in Newport, Oregon.

The Safer Society released its next survey in 1988 (Knopp & Stevenson, 1988). By this time, the field was growing and with it a rising concern about juvenile sexual abusers.

Knopp and Stevenson reported a total of 573 identified programs treating juvenile sexual offenders, and 429 programs treating adult sex offenders.

Gail Ryan began the National Adolescent Perpetrator Network (NAPN) at the C. Henry Kempe Center of the University of Colorado in 1983 and up to the present has been its principle architect. Noting the lack of research treating juvenile sexual offenders, Ryan formed a task force with four honorary appointments: Gail Ryan served as Facilitator, Fay Honey Knopp served as Honorary Chairperson, Brandt Steele served as Honorary Advisor, and Alison Stickrod served as Reporter. The National Task Force on Juvenile Sexual Offending consisted of twenty participant members and twenty advisory members selected from NAPN's membership.

The task force reviewed virtually every document published on youthful sexual abusers and created the initial working draft of the *Preliminary Report from The National Task Force on Juvenile Sexual Offending*, first published in the *Juvenile and Family Court Journal* in 1988.

In 1990, the Safer Society Foundation released its next survey on sex offender treatment programs (Knopp & Stevenson, 1990). This report identified a total of 626 programs treating juvenile sex offenders and 541 programs treating adult sex offenders. The foundation's next survey on sex offender treatment programs (Knopp, Freeman-Longo, & Stevenson, 1992) identified a total of 755 programs treating juvenile sex offenders and 745 programs treating adult sex offenders. It tracked more detail in both the treatment models and modalities used in these programs. Ten different models identified by treatment providers were now being tracked. Programs serving both juveniles and adults reported using over 50 treatment modalities and five treatment modes. In 1993, after several meetings of original and added task force and advisory members, the National Adolescent Perpetration Network published its *Revised Report from The National Task Force on Juvenile Sexual Offending in the Juvenile And Family Court Journal*.

The Safer Society Foundation documented continued growth in the field (Freeman-Longo, Bird, Stevenson, & Fiske, 1995). *The 1994 Nationwide Survey of Treatment Programs & Models Serving Abuse-reactive Children and Adolescent & Adult Sex Offenders*, noted for the first time the number of programs treating children under the age of twelve. It cited a total of 390 programs treating children and 684 programs treating adolescents. The leading treatment model for both populations was behavioral-cognitive (40% of reporting programs) followed by programs using relapse prevention (37%).

The next Safer Society report was the 1996 Nationwide Survey (Burton, & Smith-Darden, with Levins, Fiske, & Freeman-Longo, 2000). A variety of complications delayed publication of this report until 2000. The format of the 1996 survey was lengthier and more detailed. The smaller return rate of the questionnaire was presumed to result from three factors: closure of programs due to the economy, the merger of residential programs for adolescents, and the survey took more time and effort to complete than previous surveys. This report provided a summary of the previous ten years of the national survey summarized below:

Comparison of Treatment Provider Response Since 1986

Year	Adult	Juvenile	Child	Total
1986	297	346	N/A	643
1988	429	573	N/A	1,002
1990	541	626	N/A	1,167
1992	745	755	N/A	1,500
1994	710	684	390	1,784
1996	527	539	314	1,380

In 2001, the Safer Society Foundation published the next report (Burton, & Smith-Darden, 2001). This report saw a further decrease in the number of programs reporting:

Comparison of the Number of Programs by Age Group, 1986-2000

Year	Adult	Juvenile	Child	Total
1986	297	346	N/A	643
1988	429	573	N/A	1,002
1990	541	626	N/A	1,167
1992	745	755	N/A	1,500
1994	710	684	390	1,784
1996	527	539	314	1,380
2000	461	291	66	818

Again, it was noted in the 2000 report that funding issues for sex offender treatment programs continues to be a concern.

The Safer Society Foundation published its most recent report in 2003 (McGrath, Cumming, & Burchard, 2003). This report was a collaborative effort; the Safer Society used membership lists from both ATSA and NAPN, resulting in 2,289 responses.

Number of Programs in Each Survey 1986-2002

Year	Adult	Juvenile	Child	Total
1986	297	346	N/A	643
1988	429	573	N/A	1,002
1990	541	626	N/A	1,167
1992	745	755	N/A	1,500
1994	710	684	390	1,784
1996	527	539	314	1,380
2000	461	291	66	818
2002	951	937	410	2,289

This was the most comprehensive report conducted by the Safer Society Foundation. It included information about treatment models and modalities, assessment, and the use of various technologies. For example, it noted that of 937 juvenile programs, 19 used penile plethysmography, 74 used polygraph, and 42 used viewing time measures (e.g. Abel Screen). Core treatment targets for children and adolescents included offense responsibility, cognitive restructuring, intimacy/relationship skills, social

skills training, victim awareness and empathy, relapse prevention, arousal control, and family support networks.

This survey also asked questions regarding sexual arousal reconditioning techniques such as aversive behavioral rehearsal, covert sensitization, masturbatory satiation, odor aversion, and a technique called “minimal arousal conditioning”, where the youth interrupts a fantasy as soon as it becomes arousing. The results are as follows:

Male adolescent residential: 56.4% of programs use one or more.

Male adolescent outpatient: 49.4% of programs use one or more.

Female adolescent residential: 48.5% of programs use one or more.

Female adolescent outpatient: 37.2% of programs use one or more.

The most remarkable aspect of these findings is that there is no research to support the idea that youthful sexual abusers experience sexual disorders in the same ways that adults do. As mentioned elsewhere in this volume, there is evidence that sexual arousal is fluid and dynamic across adolescence (Hunter & Becker, 1994). Although sexually abusive youth can engage in sexually deviant behavior, it appears that true sexual deviance has yet to be established as a treatment target for the majority of them, while the willingness to act on sexually deviant thoughts or impulses may be more important and more amenable.

In the midst of these developments, a number of programs began to reconsider their approach towards sexually abusive youth. In Vermont, David Prescott coordinated a program that directed treatment toward developing relationships within a collaborative context. Point-and-level systems were replaced by more direct communication regarding treatment progress. Activities and family contact became fundamental components of treatment, rather than privileges. Treatment targeting sexual deviance was adjusted in accordance with the youths’ development. A prevailing belief that treatment should include full and meaningful participation by all students guided the program’s development and implementation. Many aspects of that program have been described elsewhere (Prescott, 2002).

Looking Toward the Future

The field of treating children and adolescents has grown remarkably during the past two decades. Not only has the number of programs grown, but our knowledge, treatment methods, and technology have evolved, resulting in significant changes in what we know and do today.

Understanding and working with youth is a complex and comprehensive endeavor. When young people experience mental health problems and/or become involved with the juvenile justice system, the complexity intensifies. Youth must be understood from medical, psychological, developmental, contextual, and behavioral perspectives. The recent research on brain development, family violence, trauma impact, and emerging treatment methods and models addressed in this book requires us to consistently improve our assessment and treatment methods. This is especially true for sexually abusive youth, a population that generates sobering statistics.

The National Center on Sexual Behavior of Youth (NCSBY¹), defines “*adolescent sex offenders*” as “adolescents from 13 to 17 who commit illegal sexual behavior as defined by the sex crime statutes of their jurisdictions.” While statistics vary, the Federal Bureau of Investigation crime data indicate that in 2000, juveniles accounted for 16% of arrests for forcible rape and 19% of arrests for all other sex crimes. The FBI’s Uniform Crime Reports² for 2003 indicate that juveniles committed 16.1% of forcible rapes, 20.0% of sex offenses (except forcible rape and prostitution), and 16.3% of crimes in all categories. Hunter, Hazelwood, and Slesinger (2000) note that current estimates are that youthful offenders account for as many as one third of rapes and half of all child molestation in the United States. Freeman-Longo and Blanchard (1998) report that 30-60% of all child sexual abuse is perpetrated by juveniles. The NCSBY reports that adolescent sexual offenders commit a substantial number of sex crimes, including 17% of all arrests for sex crimes and approximately one third of all sex offenses against children. Females under the age of 18, account for 8% of arrests for sex offenses. Younger children, ages twelve and under also have sexual behavior problems. NCSBY reports that of school-age children with sexual behavior problems, about one-third are female, while a recent study on preschool children found that a majority are girls.

Children are the majority of victims sexually abused by youth. Righthand and Welch (2002) state that “girls are targeted most frequently, however, boys represent up to 25% of some victim samples. Victims usually are substantially younger than the youth who offend. Victims are usually relatives or acquaintances; rarely are they strangers.” Thus, it is no surprise that the effective assessment and treatment of youth is a strong step in the prevention of further sexual victimization of children.

The “trickle-down phenomenon” of using adult-based treatment methods and models for sex offenders has occurred since the first programs for youth emerged decades ago (Chaffin and Bonner, 1998; Developmental Services Group 2000, Longo, 2003). The trickle-down phenomenon is the use of adult-based models and modalities to treat children and adolescents with sexual behavior problems and sexually aggressive behaviors. These models do not generally account for developmental factors, learning styles, and the impact of trauma in treating sexual abusers. In most cases they are sex-offender specific and seldom focus on areas outside of the sexual offending behavior. They are often forensic models developed to work with normal-functioning adults in prison-like settings. During the last few years, however, the use of adult-based treatment modal and modalities has been challenged and has come under increased scrutiny as inadequate and/or inappropriate for working with children and adolescents (Ryan & Lane, 1997; Longo, 2003; Rich, 2003).

Our new century finds growing support for the holistic/integrated model of treatment promoted in this book. It is no longer prudent to ignore the emerging research and information on child maltreatment, family violence, trauma, post-traumatic stress disorder, brain development, attachment disorders, and their respective impact on youth. The current state of our knowledge obligates us to be familiar with the latest research into assessment and treatment.

Precise language is vital to understanding and treating those who have sexually abused. Unfortunately, the terms “sex offender”, “juvenile sex offender”, and even

“predator” and “mini-perp” have become such popular vernacular that our field has used them regardless of age, developmental stage, cognitive ability, or diagnosis. Such labels often cause harm by establishing a sense of identity more than they accurately identify behavior. By telling kids who they are rather than accurately describing what they’ve done, we do further disservice to tomorrow’s adults. Additionally, not all children or adolescents with sexual behavior problems are “JSO’s” because not all have criminal convictions. Many youth charged with crimes such as statutory rape are not (other than by legal definition) sexual offenders with the intent and motivation to willfully commit a sexual offense. Not all youth with criminal charges for committing a sexual offense have a true sexual disorder, and by definition very few of them can be diagnosed as such. For example, six-year-old children who act out sexually simply do not have the motivations of older adolescents or adults. In the final analysis, we should remember that youth are more vulnerable than adults, especially with respect to the labels that we use. It is possible to confront the problem of sexual abuse while reducing the harm of the labels we use.

When working with young people, we should keep in mind that behavior is part of a person, not the whole person (Longo, 2003). Professionals must separate the person from their behavior and use precise language that promotes both accountability and optimism. As Chaffin and Bonner (1998) note:

“Fifteen years ago, our battle was getting the system to take cases seriously. We may have been too successful. Where we previously encountered public reluctance to identify the problem, we now sometimes encounter not only the willingness but also zeal. We see the labels of offender and perp placed on preschoolers. In many instances, this has extended to affixing the label of sex offender, even in advance of any actual inappropriate behavior.”

Programs will do best to operate based with developmental, contextual framework. Righthand and Welch (2002) state that, “A review of the literature conducted by the authors suggest that programs for these youths frequently have been based on knowledge and interventions designed for adult offenders without adequate consideration of the developmental issues and needs unique to juveniles. There are important distinctions that differentiate juveniles from adult sex offenders.” Many programs do not use individualized treatment plans. Few of these programs undergo periodic program evaluation, and many are based upon older models or outdated literature, and may use treatment models and modalities not suitable for young clients. Some programs are not even based upon scientific literature. The most glaring example is found in the Safer Society’s national survey of treatment programs and models. The 2000 survey conducted and published by the Safer Society Foundation, Inc., (Burton & Smith-Darden, 2001) shows that over 80% of all programs, 87.3% treating adolescents and 79.3% treating children use relapse prevention as the guiding treatment model for clients. Despite this occurrence, there are no scientific studies to support the use of relapse prevention as being more effective than any other model to treat sex offenders, and specifically children and adolescents with sexual behavior problems.

In fact, there is growing evidence (e.g., Laws, Hudson, and Ward, 2000) that the original relapse prevention model (Gray & Pithers, 1993) is not as effective as once believed. Some (e.g., Ward, Laws, & Hudson, 2003) have observed that not all abusers intend to stop abusing. In papers on pedophilia and its treatment, Nathaniel

McConaghy (1998, 1999) states that “relapse prevention treatment has been shown to be ineffective for incarcerated child molesters.” Dr. James Breiling (2002) of the National Institute of Mental Health has noted:

“From McConaghy’s paper in the ATSA journal Sexual Abuse, I am confident that his argument that relapse prevention has been shown to be ineffective for incarcerated child molesters reflects the outcome data from the exemplarily well designed treatments and experimental research design of SOTEP, the evaluation of relapse prevention for sex offenders that Janice Marques directed.

I weigh findings differentially, giving the most weight to well-designed, implemented and evaluated studies, and SOTEP is at the top of the list on all those criteria, so the lack of conclusive evidence for a treatment effect should force a serious reconsideration of the use of this model (just as strong positive findings, had they been obtained (I wish they had been) would have been a powerful launch pad for vigorous advocacy for the use of the relapse prevention model).

Youth who have sexually abused are a heterogeneous group of clients. They differ in important ways, including victim and offense characteristics, types of offending behaviors, histories of maltreatment, social and interpersonal skills levels and abilities, sexual knowledge and experience, academic, cognitive functions and mental health issues (Righthand & Welch, 2002; Longo, 2003). Their risk factors for reoffense vary, and their characteristics often do not differ significantly from youth who commit other types of crimes (Hunter et al., 2000). While relapse prevention can contribute to treatment, it can no longer be viewed as the only model. Many of the treatment models associated with relapse prevention (i.e., arousal reconditioning) may be counterproductive or harmful (Chaffin & Bonner, 1998; Chaffin, this volume). There is sparse literature suggesting that relapse prevention is useful or effective with children or adolescents, yet there are several programs that continue to use this model.

Another element found to be ineffective is the use of hostile or confrontational treatment styles. Although fewer programs openly endorse a harsh treatment style, current research stresses that a warm, empathic, rewarding, and directive approach can produce better outcomes in treating sexual abusers (Marshall, Fernandez, Serran, Mulloy, Thornton, Mann, & Anderson, 2003). Confrontational styles may also result in symptoms associated with trauma. Clinicians should re-think their goals and interactional style (Jenkins, 1990). It is worthwhile to remember that Righthand and Welch (2002) found that, “Juveniles who have offended typically are less violent than adult sex offenders.”

Other aspects of what constitutes good treatment have also changed within our field. For example, the 1992, 1994, and 1996, nationwide surveys conducted by the Safer Society Foundation saw empathy enhancement emerge to be the leading treatment modality in both juvenile and adult programs (Knopp, Freeman-Longo, & Stevenson, 1992; Freeman-Longo, Bird, Stevenson, & Fiske, 1995; Burton, Smith-Darden, Levins, Fiske, & Freeman-Longo, 2000). However, in the 2000 survey (Burton & Smith-Darden, 2001), empathy training had dropped off to where it was being used by less than 7% of programs treating adolescents and adults.

From a holistic or integrated perspective, sexual behavior problems are part of a bigger picture (Longo, 2001; Longo, 2002, Longo & Longo, 2003). One can hardly expect to treat a young person who has stolen underwear without addressing his ecology and willingness to break rules. All too few treatment programs are based in a developmental framework.

Questions remain around intensity and dosage of treatment. At this time, managed care and tight budgets have led some programs to reduce the length of treatment. This has been an ongoing dialog among some programs for nearly a decade. According to the Safer Society nationwide survey 2000 (Burton & Smith-Darden, 2001), the average length of treatment for community-based programs ranges predominantly between 12-24 months for adolescents and 6-12 months for children. Some programs are less than twelve months and in some cases are six months, while others keep clients for over 24 months. Residential programs for adolescents range between 12-24 months, and from under six months to over 24 months for children. The average is eighteen months for both residential and community-based treatment for adolescents and seven months for community-based treatment, and thirteen months for residential treatment with children.

Significant differences among research findings became highly apparent during our research for this book. Such differences might reflect the diversity of the populations studied. One would expect to see differences between youth in a community-based versus secure residential treatment program. However, we do not see uniformity between programs in the use of psychometric measures, risk assessment strategies, and program design. Some programs do not work with youth with mental illness, while others do. The use of different treatment models, treatment modalities, length of treatment, acceptance criteria, discharge criteria, what constitutes program completion, etc., likely all factor into the differences we see in the literature. So, at the very least, one must be cautious about what we read.

The chapters in this book address these and other issues. Despite the politics and economics that often govern our work, we believe that professionals must always be cognizant of emerging issues and changes in the field. We hope the chapters in this book will lend insight as well as challenge the ways that we do our work.

Summary

The rapid advances in the study of sexually abusive youth, although well meaning and praiseworthy, has often narrowed our focus to elusive sexual aspects at the expense of a full accounting of the youth's development and ecology. While there is much in youthful development to distract us from a clear understanding of potential re-offense processes, we can no longer allow adult programming to be the sole source of assessing and treating young people. It is for this reason we have collected the chapters in this book.

End Notes

¹<http://www.ncsby.org/pages/publications/What%20Research%20Shows%20About%20Adolescent%20Sex%20Offenders%20060404.pdf> - retrieved January 5, 2005.

²http://www.fbi.gov/ucr/cius_03/pdf/03sec4.pdf

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