Juvenile Sex Offenders

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KEYWORDS

• Juvenile sex offenders • Paraphilias • Risk factors • Risk assessment
• Sex offender registries • Psychopathology • Sex offender treatment

KEY POINTS

- Sexual offending by youth is a serious problem, with approximately half of all sex offenses against children committed by individuals younger than age 18.
- Juvenile sex offenders (JSOs) comprise a heterogeneous group, and a majority of youth do not go on to develop paraphilias or to commit sex offenses during adulthood.
- As a group, JSOs are more similar to general delinquents than to adult sex offenders.
- Empirically supported risk factors for sexual reoffending in male juvenile offenders include deviant sexual interest, numerous past sexual offenses, and selection of a stranger.
- JSO risk assessments are increasingly used to inform sentencing and postsentencing decisions and hence must be performed by clinicians who possess excellent clinical skills, a thorough knowledge of normal child and adolescent development, a thorough knowledge of child and adolescent psychopathology and abnormal developmental trajectories, and an up-to-date knowledge of the research.

SCOPE OF THE PROBLEM AND DEFINITIONS

Sexual abuse by youth is neither rare nor inconsequential; victims of sexual assault suffer a variety of sequelae, including posttraumatic stress disorder (PTSD), major depression, and substance abuse.[1] Youth under the age of 18 are responsible for between 15% and 20% of all sexual offenses and up to 50% of all sexual offenses against children.[2] It has been estimated that one-third to one-half of adult sex offenders began offending as youth,[3] which can lead to the erroneous conclusion that intractable deviant sexual arousal is at the root of all sexual offending and that sexual offending youth are merely future adult sex offenders who have been caught early. As discussed throughout this article, JSOs are not just youthful adult sex offenders. They comprise a far more heterogeneous group than adult sex offenders. It is important to

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keep in mind 2 often reiterated caveats: (1) most juveniles who commit sex offences do not go on to become sex offenders in adulthood and (2) most JSOs do not go on to develop paraphilias.

Extant research indicates that JSOs recidivate sexually at a lower rate than adult sex offenders, with most estimates of sexual reoffending ranging between 8% and 14%,[4] An examination of recidivism studies that included 11,219 JSOs with a mean follow-up period of 5 years found a mean base rate of 7.08% for sexual reoffending but a 43.4% mean base rate for general reoffending.[4] Other studies have found rates of nonsexual recidivism of 28% to 54%.[5–10] JSOs much more likely to reoffend nonsexually than sexually, and most sexual and nonsexual recidivism occurs within 3 years of release.[7,10] More recent research has focused on the ways in which JSOs are different from adolescents with histories of nonsexual offending in an effort to better identify and treat youth at risk for recidivism.[11]

The term, *sexual offender*, technically relates to an individual who has been convicted of a sexual crime and should not be assumed synonymous with any specific mental disorder(s), including paraphilias. In this article, however, the term, sex offender, is used synonymously with juveniles who engage in behaviors that meet the threshold for charges, whether or not they actually have involvement with the legal system. Management of JSOs has become more punitive over the past couple of decades. Youth as young as 10 years of age may be required to register as predatory sexual offenders for their lifetimes. Ironically, requiring convicted juveniles to be added public sex offender registries has resulted in some prosecutors being reluctant to pursue convictions and an increase in plea bargain deals, including sex offense charges amended to nonsexual charges and lower severity charges.[12] Additionally, it seems that juvenile registration has little deterrent effect on behavior considered to be sexual offenses.[13]

WHAT CAUSES JUVENILE SEXUAL OFFENDING?

There are undoubtedly a variety of etiologies of sexual offending. Biological, familial, societal, and developmental factors have all been postulated as playing a role in the onset and continuation of sexual offending. As discussed in this article, JSOs are a varied group, and the onset of sexual offending in a specific person is as unique as the individual. A comprehensive theoretic framework regarding the cause of sexual offending is lacking. Descriptive studies categorize JSOs into 3 groups: (1) those with underlying sexual deviation, (2) those with a general antisocial orientation, and (3) those with traits that indicate more general psychopathology.[14] Although numerous theories regarding the etiology of sexual offending in adults have been proposed,[15–17] there is no generally accepted theory regarding the cause of sexual offending in youth. Several etiologic factors have received empirical and clinical interest, however, including a history of maltreatment, especially sexual abuse; exposure to pornography; and exposure to aggressive role models.[18]

Ryan and colleagues[19] proposed a model of sexual offending that begins with a negative sense of self, in which vulnerable children and adolescents protect themselves from what they predict will be negative and hurtful interaction by social withdrawal and isolation. They retreat into fantasy to compensate for feelings of powerlessness and helplessness. When sexual offending occurs, there is a further increase in negative emotions and self-image and thoughts of rejection, establishing a destructive repetitive cycle. In the Marshall and Barbaree model,[20–22] children learn that they are more successful at getting their parents' or caretakers' attention by being disruptive, which in turn leads to caretakers adopting an aggressive, coercive, and

manipulative parenting style, which limits children's experiences of prosocial, nurturing interactions. When children enter school, they are less likely to successfully manage impulses and negotiate positive, healthy relationships with peers or teachers. These relationship problems lead to a negative self-image and lack of confidence. From there, what the investigators call a "syndrome of social disability" develops, with the emergence and consolidation of sexually abusive behavior as part of a larger framework of antisocial or delinquent behavior. This theoretic model suggests that understanding and tackling those aspects of the family that promote criminal behavior are critical in the development of a treatment plan.

Becker and Kaplan[23,24] proposed that the first sex offense results from a combination of individual characteristics, including a lack of social skills, a history of nonsexual deviance, family variables, and social-environmental variables, such as social isolation and antisocial behavior. After the first sex offenses, youth may pursue 3 possible paths: (1) a dead end, in which there are no further crimes; (2) a delinquency path, in which the juvenile engages in continued sexual offending and in general nonsexual offenses and deviant behaviors; and (3) a sexual interest path, in which the juvenile continues to commit sexual offenses and develops a paraphilia. Shaw and Antia[25] identified 4 types of JSOs: (1) youth with true paraphilias, (2) youth with strong antisocial personality traits, (3) youth compromised by a neurologic disorder (mental retardation, autistic spectrum disorder, and so forth), and (4) youth with impaired social skills who turn to younger children for sexual gratification. Hunter and colleagues[26] noted that male adolescents who offended against prepubescent children had greater deficits in psychosocial functioning, engaged in less aggression during the offense, and were more likely to offend against relatives. Physical abuse by a father or stepfather and exposure to violence against girls and women were found associated with higher levels of comorbid anxiety and depression among youthful sex offenders. Noncoercive childhood sexual abuse by a male nonrelative was found associated with sexual offending against a male child.

RISK FACTORS FOR JUVENILE SEXUAL OFFENDING

Long before research on JSOs, deviant sexual arousal was noted in adult male sex offenders. Deviant sexual interest is clearly a risk factor for recidivism in adults, with studies of male sexual offenders indicating that most of the participants had developed deviant arousal in adolescence. Abel and colleagues[27,28] reported that 42% of adults diagnosed with paraphilias reported deviant sexual arousal by 15 years of age and 57% by age 19.

In the past, youth who engaged in sexually offensive conduct were frequently perceived as engaging in sexual experimentation than criminal behavior. Although some adolescents and children are sexually reactive and engage in sexually offensive behavior as part of a phase related to inappropriate sexual exploration, this should not be automatically assumed. A minority of adolescents do have deviant sexual arousal patterns, have had prior victims, and are beginning a pattern of behavior that is similar to that of adult paraphilic sexual offenders.[9,29] Recent research has attempted to focus on better understanding and improved identification of youth who may be at higher risk for adult sex offending.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition),[30] paraphilias are characterized by "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners." (See **Box 1** for a brief description of individual paraphilias.) To qualify for the diagnosis of a paraphilia, these

Box 1
Paraphilias

Pedophilia

Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with prepubescent children (usually age 13 years or younger) over a period of ≥6 months. The individual is age ≥16 and ≥5 years older than the child. The individual has acted on the urges or they cause significant distress or interpersonal difficulty.

Voyeurism

Recurrent, intense sexual arousal over a period ≥6 months, as manifested by fantasies, urges, or behaviors from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity. The individual has acted on the urges or they cause significant distress or social or occupational difficulty.

Exhibitionism

Recurrent, intense sexual arousal, over a period ≥6 months, from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors. The individual has acted on the urges or they cause significant distress or social or occupational difficulty.

Frotteurism

Recurrent and intense sexual arousal from touching or rubbing up against a nonconsenting person, as manifested by fantasies, urges, or behaviors, over a period ≥6 months. The individual has acted on the urges or they cause significant distress or social or occupational difficulty.

Sexual masochism

Recurrent, intense sexual arousal from being humiliated, beaten, bound, or otherwise made to suffer, over a period ≥6 months, as manifested by fantasies, urges, or behaviors. The individual has acted on the urges or they cause significant distress or social or occupational difficulty.

Sexual sadism

Recurrent, intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors, over a period ≥6 months, The individual has acted on the urges or they cause significant distress or social or occupational difficulty.

Fetishism

Recurrent, intense sexual arousal from either the use of nonliving objects or a highly specific focus on nongenital body parts, as manifested by fantasies, urges, or behaviors, over a period of ≥6 months, causing significant distress or impairment in social or occupational functioning.

Transvestism

Recurrent, intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviors, over a period of ≥6 months, with significant distress or impairment in social or occupational functioning.

Zoophilia

Recurrent, intense sexual arousal involving animals as manifested by fantasies, urges, or behaviors, over a period of ≥6 months, with significant distress or impairment in social or occupational functioning.

Coprohilia

Recurrent, intense sexual arousal from feces as manifested by fantasies, urges, or behaviors, over a period of ≥6 months, with significant distress or impairment in social or occupational functioning.

Urophilia

Recurrent, intense sexual arousal from urine, as manifested by fantasies, urges, or behaviors, over a period of ≥6 months, with significant distress or impairment in social or occupational functioning.

Necrophilia

Recurrent, intense sexual arousal from corpses, as manifested by fantasies, urges, or behaviors, over a period of ≥6 months, with significant distress or impairment in social or occupational functioning.

Klismaphilia

Recurrent, intense sexual arousal from enemas, as manifested by fantasies, urges, or behaviors, over a period of ≥6 months, with significant distress or impairment in social or occupational functioning.

Telephone scatologia

Recurrent, intense sexual arousal from making obscene phone calls, as manifested by fantasies, urges, or behaviors, over a period of ≥6 months, with significant distress or impairment in social or occupational functioning.

Data from American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-5). 5th edition. Washington, DC: American Psychiatric Association; 2013.

behaviors must have occurred for at least 6 months and have caused distress or impairment that impedes social, occupational, or other important areas of functioning. Deviant sexual arousal is a critical component of any paraphilia.

Identifying and targeting paraphilias in adult sex offenders are critical in evaluation and treatment planning. Adults with paraphilias are at increased risk for sexual reoffending.[31–34] Most juveniles who engage in sexually offensive behavior do not go on to develop a paraphilia, but some will.[27] Identifying those adolescents at risk for developing paraphilias and reoffending sexually is one of the most vexing of challenges. The adult literature is not terribly helpful when applied to juveniles. As an example, consider the use of phallometric testing, or penile plethysmography, considered the gold standard of objective measurement of sexual arousal in men based on extensive research on its reliability and validity.[35] Among adult sex offenders, deviant sexual arousal as measured by penile plethysmography has been noted the most predictive factor for sexual reoffending among pedophilic adult sex offenders[32]; however, in adolescents the results are mixed.[36] Gretton and colleagues[37] reported no association between repeated sexual offending and deviant sexual arousal in JSOs as measured by phallometric assessment in an outpatient sample of 220 male juvenile offenders; however, they did find that juveniles with both elevated psychopathy and deviant sexual arousal were at increased risk for general recidivism. A more recent study considered the discriminative and predictive validity of the penile plethysmography in a sample of 132 male adolescent sex offenders admitted to a sex offender treatment

program. The subjects were assessed pretreatment and post-treatment, under an "arouse" condition (subjects allowed themselves to become aroused) and a "suppress" condition (subjects attempted to suppress or control their arousal). Post-treatment arousal and inability to suppress arousal to male and female children were significantly related to sexual offense recidivism.[38]

Risk assessments are increasingly used to inform decisions regarding sentencing and postsentencing conditions, including community notification and registration, treatment needs, and supervision requirements. A risk assessment is, therefore, a high-stakes evaluation, and evaluators must possess a thorough and up-to-date knowledge of the ever-expanding research on juveniles as well as excellent clinical skills and adequate time to perform an evaluation thoroughly.

Vignette 1

Joe is a 14-year-old boy with a full-scale IQ of 72 and a history of anxiety, depression, ADHD, and sexual abuse by a neighborhood adolescent, who revealed during a therapy session that he was "playing" with his 6-year-old sister while minding her when his single-parent mother was working during the evenings. His description of the "play" revealed mutual fondling, with clothes off, which began several months ago when he was bathing his sister prior to her bedtime and progressed to intercourse. His therapist, as a mandated reporter, informed child protective services. Joe was subsequently charged with a sexual felony, placed in a juvenile detention center, and quickly transferred from juvenile to adult court. A psychosexual evaluation did not indicate evidence of deviant sexual arousal. Joe was found incompetent to stand trial and spent about 9 months being restored to competency in the detention center. At age 16, Joe ultimately pleaded guilty in a deal that allowed him to serve his sentence in juvenile corrections, where he was remanded until age 21, and placed on the adult sexual offender registry for life.

Vignette 2

Robbie is a 15-year-old boy who was in the custody of social services for 3 months, when he was taken into custody after several boys and girls, ages 4 to 8, revealed to their parents that Robbie has fondled them and forced them to masturbate him at a church camp. A police examination of the biological family's computer revealed numerous downloaded images of sexual acts involving very young children; however, it could not be proved that Robbie was the individual who downloaded the images, and his father, who denied knowing about the images, was recently incarcerated for sexually abusing a 12-year-old cousin. Robbie denies a history of sexual abuse or physical abuse but has witnessed domestic abuse. His mother was arrested for prostitution several months ago, but the charges were dropped. Robbie has several friends and is a good student and on the high school track team. He denies that he is gay but does not have a girlfriend, indicating that he is too young to be interested in girls.

- *These 2 cases reveal the importance of thorough clinical evaluation and risk assessment as well as a knowledge of empirically validated risk factors for reoffending. The fact that penetration was involved in Joe's case does not increase his risk for sexual recidivism. A risk assessment evaluation may have revealed that the convergence of cognitive limitations, social isolation and poor social skills, poor supervision, and opportunity were critical risk factors for the initiation of Joe's abuse of his sister. Although extant research indicates that a history of sexual abuse may be a risk factor for the initiation of sexual abuse, especially in combination with other risk factors, it is not a risk factor for sexual recidivism.*
- *Joe's ultimate fate reveals the reality of overcharging youth who have committed sexual offenses and are at low risk for sexual recidivism—delayed or minimal treatment and the imposition of long-standing or even lifelong obstacles to employment (felony criminal record and sex offender registration) and adult independence in a youth who already has a variety of vulnerabilities.*

- *Robbie, despite his intelligence and involvement in prosocial activities, presents with several risk factors for sexual reoffending, most importantly multiple stranger victims, and several red flags for possible deviant sexual arousal that should be carefully assessed, including probable exposure to child pornography, even if he did not download the images; exposure to parental sexuality and violence; and an apparent lack of sexual interest in same-age peers.*
- *At first glance, Robbie's risk for sexual reoffending seems much higher than Joe. If a thorough sex offender risk assessment bears that out, he should receive sex offender–specific treatment in a residential facility.*

Worling and Langstrom[39] divided risk factors for sexual recidivism into 4 categories: supported, promising, probable, and unlikely. Empirically supported risk factors for recidivism include deviant sexual interest, attitudes supportive of sexual offending, numerous past sexual offenses, selection of a stranger, lack of intimate peer relationships or social isolation, high-stress family life, problematic parent-offender relationships, and incomplete sex offender treatment. Risk factors are difficult to measure, however, and have not been validated as predictive of recidivism in any sex offender risk assessment instrument. Also, some of the risk factors associated with reoffense are nonspecific and associated not only with nonsexual delinquency but also with compromised mental health in general.

Christiansen and Vincent[40] studied 39,248 adjudicated juvenile sexual and nonsexual offenders ages 7 to 18 years in Maricopa County, Arizona. The sexual reoffense rate was 4.2%, and the reoffense rate for nonsexual crimes was 40.96%, reflecting the trend noted in other studies; that is, as a group JSOs are far more likely to recidivate nonsexually than sexually. The fact that only 1.77% of the sample had any adjudicated sex offense illustrates the problem that extremely low base rates presents in the prediction of both juvenile sexual offending generally and reoffending in particular. The extremely low base rate makes development of an instrument that effectively and specifically identifies only those juveniles at risk for reoffending sexually very difficult. In this study, among the strongest predictors of sexual recidivism were prior nonsexual offending, prior sexual offending, hands-off offending, offending against a child, not attending school, and younger school grade/age at the time of the initial offense.[40]

Recent research has focused on distinctions between the larger generalist group and much smaller group of specialist JSOs. Seto and Lalumière[11] conducted a meta-analysis of 59 studies comparing male adolescent sex offenders (N = 3855) with adolescent offenders who had not committed sexual offenses (N = 13,393) on a variety of variables, including conduct problems and criminal involvement, maltreatment and exposure to violence, substance abuse, family and interpersonal problems, sexuality, and psychopathology. The results of their meta-analysis revealed that on many variables the 2 groups did not differ, including antisocial personality traits, attitudes, and beliefs; early conduct problems; intelligence; social problems; and general psychopathology. Adolescent sex offenders had a less extensive criminal history, less substance abuse, and fewer delinquent friends. Adolescent sex offenders also differed from their generalist peers with respect to variables related to psychosexual development and maltreatment history; they were much more likely to have been sexually abused and more likely to have been physically and emotionally abused. Adolescent sex offenders were more likely to have had early exposure to sex or pornography, exposure to sexual violence within the family, and atypical sexual interests (eg, sexual fantasies involving young children or coerced sex). The largest

differences found were with respect to atypical sexual interests and sexual abuse history. The investigators suggested that although adolescent sex offenders and general delinquents share many of the same risk factors for offending, to understand why an adolescent commits a sex offense rather than a nonsexual offense, special factors, including a history of sexual abuse, exposure to sex or pornography, and atypical sexual interests, need to be considered.[41]

PSYCHIATRIC EVALUATION AND PSYCHOPATHOLOGY

Several studies of adult sex offenders with paraphilic and nonparaphilic deviant behavior have indicated high rates of comorbid psychiatric disorders, especially mood, anxiety, substance abuse, and personality disorders.[42–45] The few studies of comorbidity in adolescent sex offenders indicate a high incidence of diverse psychiatric pathology. Sex offending is a behavior, however, not a diagnosis, and as such has numerous causes and manifestations.[46] Psychiatric evaluation disconnected from risk assessment is of limited utility. Psychiatric disorders, with the infrequent exceptions of mania and psychosis, do not "cause" sexual offending; however, ignoring psychiatric comorbidity in offenders can seriously compromise the efficacy of structured sex offender treatment. There are few studies of psychopathology among JSOs. A study that identified 34 JSOs broken out of a sample of 242 chronic violent juvenile offenders found few characteristics associated with conduct disorder, with fewer drug and alcohol problems and less frequent involvement in gangs. These JSOs were more likely to have been raised in families with spousal violence, physical abuse, and sexual abuse. They were more sexually and socially isolated, with stronger beliefs in law and order but fewer internal controls on their behavior.[47] Another study of psychopathology in 58 male sex offenders ages 13 to 18 referred for outpatient evaluation and treatment found conduct disorder the most prevalent diagnosis (48%), with 8.3% meeting criteria for alcohol abuse, 10.3% for both alcohol and cannabis abuse, 8.6% for adjustment disorder with depressed mood, 6.9% for attention-deficit/hyperactivity disorder (ADHD), and 5.2% for social phobia. No diagnosis was found in 19.2%, with the investigators hypothesizing that the lack of more severe psychopathology was related to the fact that more severely affected sexual offenders were referred to hospital or residential programs.[48]

Personality pathology in sexually offending youth has received research attention, but findings are often contradictory, which is not surprising, given the heterogeneity of this population. Psychopathy, a multidimensional construct or personality style, encompasses interpersonal (manipulative or grandiose), affective (callous or shallow), lifestyle (impulsive or stimulation seeking), and antisocial (criminal orientation) features and is of interest because of its robust association with general and violent crime.[49] Psychopathy has been noted in several studies to predict general and sexual recidivism in adolescent boys.[37,50] There is controversy around the stability of psychopathic traits into adulthood and concerns regarding the potential misuse of the diagnosis to divert adolescents into correctional facilities rather than into treatment.[51] Also, psychopathy does not seem a useful predictor of violent or nonviolent recidivism in girls.[52]

Although there is limited research on psychopathology in JSOs specifically, research over the past 10 to 15 years on delinquent youth generally (which includes sex offenders) indicates that the prevalence of mental illness is much higher in incarcerated youth than in the general adolescent population. A meta-analysis of the research on the prevalence of mental disorders among incarcerated juveniles in short-term detention and longer-term correctional facilities involving 13,778 boys and 2972 girls (ranging from 10 to 19 years, with a mean age 15.6 years)[53] found

that among boys, 3.3% were diagnosed with psychosis, 10.6% with major depression, 11.7% with ADHD, and 52.8% with conduct disorder. Among the girls, 2.7% were diagnosed with psychosis, 29.2% with major depression, 18.5% with ADHD, and 52.8% with conduct disorder. The prevalence of major depression found in delinquent girls (29.2%) is considerably higher than found in adult female prison populations (12%).[54]

In a randomly selected sample of 1172 male and 657 female detainees studied over 6 months,[55] approximately half had substance use disorders, with 21% having 2 or more disorders. Of those youth with any substance use disorder, approximately 50% also had an alcohol use disorder.

Trauma and PTSD are more prevalent among detained youth than in community samples, with 83% of boys and 84% of girls among 898 youth ages 10 to 18 years reporting at least 1 traumatic experience, and 11% of the sample meeting criteria for PTSD with the past year.[56,57] Among youth with PTSD, comorbidity was the rule rather than the exception with 93% having at least 1 and 54% having 2 or more comorbid psychiatric disorders (mood, anxiety, or behavioral or substance abuse disorders), and 11% having 4 comorbid disorders. Among 1829 newly detained youth ages 10 to 18 years, more than one-third of detainees and approximately one-half of the girls felt hopeless and had thoughts of death in the 6 months prior to detention, with 10% considering suicide and 10% having made a suicide attempt in the past 6 months.[58]

FEMALE JUVENILE SEX OFFENDERS

Adolescent female sex offenders are an understudied group for 2 reasons: (1) the small numbers of girls who commit sexual offenses and (2) the low rates of sexual recidivism for female sex offenders. It has been estimated that only approximately 5% to 10 % of all juvenile sex offenses are committed by female adolescents,[59,60] and a meta-analysis of 10 studies of the recidivism rates of female adolescents who had committed sex offenses with an average follow-up of 6.5 years found that less than 3% recidivated.[61]

A study of female adolescent sex offenders in Washington state[62] showed that risk factors for general recidivism were least common in female adolescents who had committed a felony sexual offense against a younger child, and these girls had fewer problems in the domains of school, family, and friends than did adolescent girls who had committed a misdemeanor sexual offense or a felony sexual offense with a peer victim. Girls who had committed a felony offense against a peer or a misdemeanor sexual offense more closely resembled female adolescent nonsexual offenders. They demonstrated a high prevalence for risk factors for general (nonsexual) recidivism, such as severe behavior problems in school, truancy, parental alcohol and mental health problems, running away, out-of-home placements, poor parental control, and delinquent friends. There were no differences in mental health problems. These findings mirror results from studies of adolescent male sex offenders, in that those adolescents who abused children were less similar to nonsexual offending delinquents than peer abusers and had a low prevalence of risk factors for general recidivism. In another study using the same cohort, sexual victimization by a nonrelative was the only characteristic that distinguished girls who had committed sexual offenses from adolescent male sex offenders and adolescent female nonsexual violent offenders.[63]

TESTING AND USE OF STRUCTURED INSTRUMENTS

In the assessment of adult sex offenders, actuarial measures, such as the Static-99 and Static-2002, which are supported by more than 60 validity studies, are a mainstay

of evaluation[64,65] The evaluation of sexually offending youth requires far more than psychological assessment instruments, and at present there is no instrument or measure that predicts sexual offending or recidivism. This is not surprising given that the base rate of sexual recidivism is low and most juvenile sexual offenders are more similar to other delinquents than to adult sex offenders and are more likely to commit a nonsexual offense than a sexual offense. The outcome of sexual recidivism is a highly unusual one, and it is extremely difficult to develop an actuarial instrument that is able to predict such an unusual outcome.

The 3 instruments most frequently used in JSO evaluations are the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II), the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR), and the Psychopathy Checklist: Youth Version (PCL:YV). The J-SOAP-II, an empirically informed guide designed for use in boys ages 12 to 18 for the assessment of risk factors associated with sexual and violent offending, is one of the most commonly instruments in the United States.[66] Results are mixed, however, with for the instrument as a whole or for individual subscales to predict sexual or nonsexual recidivism.[67] Recent studies indicate that it can be a useful adjunct to assessment, but additional risk assessment is necessary for a thorough evaluation.[68]

Results for the ERASOR,[69] which has the stated purpose of only predicting sexual recidivism, are likewise equivocal.[67] A recent meta-analysis of risk assessment instruments found that tools specifically designed for adolescents did not outperform the Static-99, which was developed for adult sex offenders and is not recommended for use in juveniles. The investigators note, however, that the overlap in risk factors for adolescent and adult offending as well as the effect size for the Static-99 likely contributed to the findings.[70]

The PCL:YV, although a strong predictor of general recidivism, does not predict sexual recidivism,[67] although in 1 study an extremely high (greater than 34) score on the PCL:YV was predictive of sexual recidivism.[71]

TREATMENT

Given the heterogeneity of JSOs, a one-size-fits-all approach to treatment is ill advised, and treatment should be tailored to individual youths and to the risk factors uncovered from a comprehensive psychiatric evaluation and forensic risk assessment. Treatment should target dynamic risk factors as well as protective factors identified in evaluation and risk assessment, and any treatment program, whether it is an outpatient community treatment program or a residential program, should have procedures in place for ongoing assessment of dynamic risk factors. Without an understanding of the risk factors specific to the individual youth and to the offense, it is impossible to assess the significance and impact of those factors to the youth and the offense and plan for treatment. For example, if depression had little to do with the offense, treating depression in the JSO with paraphilic arousal, although a clinical and moral imperative, does little to minimize the risk of reoffending either generally or sexually. It is the deviant sexual arousal that presents the most risk of sexual reoffending and that needs to be specifically addressed in treatment.

Although additional research on empirically validated treatment approaches for sexually offending youth is sorely needed, there are interventions that have some demonstrated efficacy, but adopting them has been slow. The prevailing approach used in outpatient and residential treatments is a combination of cognitive behavioral group therapy and relapse prevention.[72] A 20-year prospective follow-up study found that the base rates for sexual (9%), nonsexual violent (22%), nonviolent (28%), and

general reoffending (38%) were significantly lower for youth who participated in specialized treatment versus a comparison group (with 21%, 39%, 52%, and 57% base rates, respectively).[73]

All adjudicated JSOs should be engaged in sex-offender specific treatment, including individualized sex-offender specific services to those youth returning to the community from residential placement. This transition from residential treatment (whether court-ordered in a private facility or in a juvenile correctional program) is where treatment planning and execution frequently falls apart, leaving both the juvenile and community vulnerable. Hunter developed guidelines for making level-of-care determinations on JSOs for the Virginia Department of Juvenile Justice, with the intention of complementing, not replacing, formal clinical and risk assessment.[74] He developed clinical profiles for youth at "low," "moderate," and "high" risks of reoffending based on a youth's sexual offenses and criminal history, psychosexual characteristics, peer affiliations and family characteristics, and past response to treatment. Low risk youth were characterized as those that had engaged in nonviolent, time-limited (1 to 2 times) sexual behaviors that were relatively noninvasive and noncoercive and typically exploratory and opportunistic (eg, fondling of younger siblings or children for whom the offender was babysitting). These low-risk offenders had no or minimal criminal histories and age-appropriate sexual interests and were without a history of prior sexual offending or inappropriate sexual behavior. Their families were not highly dysfunctional. The low-risk offender is appropriate for community-based care and probation. Moderate-risk offenders' sexual offending began in adolescence and they engaged in sexual offenses that involved trickery or mild physical or verbal coercion; however, the offenses were nonviolent in nature. The offense may have involved fondling, exposure, oral sex, or attempted vaginal or anal intercourse. The victims were not strangers, and typically younger siblings or family members or acquaintances. The moderate-risk offenders come from moderately dysfunctional families and have a history of maltreatment or exposure to antisocial behavior; parents may minimize the significance of the adolescent's behavior and/or feel overwhelmed and unable to cope. In Hunter's guidelines, moderate-risk youth are seen as requiring more intensive, wrap-around community-based services and court supervision. High-risk offenders were characterized as those who engage in planned sexual offenses that involved the use of threats, deception, or physical force and involved vaginal or anal penetration, with multiple incidents extending over a period of time. Offenders with stranger victims were placed in this category. A history of nonsexual or sexual offenses of a highly aggressive nature is present. These youth show evidence of deviant sexual interests or antisocial personality traits, and offending against younger children reflects pedophilic interests. Offending against same-age peers or adults reflects endorsement of rape myths and fantasy. The youth does not learn from past experiences and repeats problematic behavior in multiple environments. The family system is typically moderately to severely dysfunctional. The high-risk offender generally required residential treatment (in a juvenile justice facility or court-ordered) with 24-hour supervision and care.

For juveniles identified as a generalist offenders, proved treatments targeting delinquency are warranted, such multisystemic therapy (MST), functional family therapy, or multidimensional family therapy. For specialist offenders, treatments such as cognitive behavioral therapy focusing on management of atypical and deviant sexual arousal as well as sexual preoccupations may be beneficial. Even in the adult literature, treatment outcome studies must be interpreted cautiously, given their methodological limitations. A meta-analysis by Hanson and colleagues[75] examining treatment efficacy with adult male offenders found that cognitive behavioral therapy significantly

decreased sexual recidivism compared with no treatment (12% sexual recidivism vs 17% without treatment). In a 20-year follow-up of adolescents who received specialized community-based treatment, Worling and colleagues[73] found that those who participated in specialized treatment, the Sexual Abuse: Family Education and Treatment Program, were significantly less likely than those in a comparison group to receive subsequent charges for sexual (9% vs 21%), nonsexual violent (22% vs 39%), and nonviolent crimes (28% vs 52%). The program contains a major family component, as do other successful programs targeting this population.[76–78]

A 2-year follow-up of a randomized effectiveness trial evaluating MST supported the ability of MST to sustain positive changes among juvenile sexual offenders. Although sexual recidivism was too low to conduct statistical analysis, there was no between-groups difference with respect to rearrests for nonsexual offenses.[78]

A small percentage of juvenile substance users requires residential treatment. One of the major drawbacks of residential treatment is that their distance from youths' families makes frequent necessary family work difficult if not impossible. It is this author's opinion that the unfortunate practice noted in recent years of conducting family work by phone (which is billable as family therapy) is a poor substitute for the type of intensive family engagement and therapy that most of these youths' families require. It is known that too much intervention with nonsexually offending juveniles does little good and may actually have negative effects. If the goal is to decrease subsequent delinquent and criminal behavior, juvenile offenders with low risk for reoffending should be diverted from the juvenile justice system. Subjecting delinquents to punishments and interventions beyond what is necessary actually increases the risk of recidivism.[79]

Pharmacologic Treatment

JSOs may also have co-occurring psychiatric disorders, especially mood and anxiety disorders as well as ADHD for which pharmacologic treatment is indicated. Unless their psychiatric disorders are appropriately treated, afflicted youth may be unable to participate fully in sex offender treatment. Unfortunately, the quality of the evidence base for pharmacologic treatments of sexual offending, which is almost entirely for adults, is poor. The World Federation of Societies of Biological Psychiatry developed guidelines on the biological treatment of adults with paraphilias.[80] There is even less research available to guide decision making in the pharmacologic treatment of adolescents with paraphilias. The gold standard of demonstrating pharmacologic efficacy is the randomized, double blind, placebo-controlled trial. Although selective serotonin reuptake inhibitors (SSRIs) have enjoyed widespread use with the goal of decreasing sexual obsessions and compulsive sexual behavior in both adults and youth, there are no randomized placebo-controlled studies of their use in paraphilias. Because of their methodological limitations, a critical analysis of all published studies concluded that there was only minimal research evidence to support their efficacy.[80] Because of their ease of use and favorable side-effect profile (including the typically undesired side effect of decreased libido), however, SSRIs are the most frequently used medication used targeting sexual behavior in sexually offending juveniles. The similarities between obsessive-compulsive disorder and paraphilic and nonparaphilic sexual disorders have been noted by Bradford and others.[81–83] Despite the frequency with which SSRIs are used in the juvenile offender population, especially targeting deviant arousal, there are only 2 open label trials an SSRI (fluoxetine) targeting paraphilic behavior described in the literature, both with a positive response.[84,85]

A minority of adolescent sex offenders do have deviant sexual arousal/paraphilias and have reoffended repeatedly. Treatment with hormonal agents, such as medroxyprogesterone acetate and luteinizing hormone-releasing hormone, however,

frequently used in adult repeat offenders, is rarely used with adolescents in the United States secondary to their side-effect profiles and as-yet unknown potential sequelae in adolescents who are still developing. For a more in-depth discussion of hormonal agents, readers are referred to the review of biological therapies by Ryan.[86]

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