Adolescents With Illegal Sexual Behavior: Current Knowledge

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

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

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

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

Research on adolescent males with illegal sexual behavior has focused on their characteristics, establishing a typology, their level of risk for reoffense, and their recidivism. It is notable that only a handful of studies have compared treatment approaches and only recently has a major randomized clinical trial been funded (see Letourneau & Borduin, in this issue.) Research has documented that AISB are a heterogeneous group of boys with differences in abuse history (Veneziano, Veneziano, & LeGrand, 2000); characteristics of the victims, such as age and gender (Fehrenbach, Smith, Monastersky, & Deisher, 986); violence (Hunter, Hazelwood, & Slesinger, 2000); level of risk for recidivism (Kemper & Kistner, 2007; Parks & Bard, 2006); and treatment effectiveness (Reitzel & Carbonell, 2006).

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

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

- AISB are considered to be more responsive to treatment than adult sex offenders and do not appear to continue reoffending into adulthood, especially when provided with appropriate treatment (ASTA, 2000);

- Adolescents have fewer numbers of victims than adult offenders and, on average, engage in less serious and aggressive behaviors (Miranda & Corcoran, 2000);

- Most adolescents do not have deviant sexual arousal and/or deviant sexual fantasies that many adult sex offenders report (Hunter, Goodwin, & Becker, 1994; Becker, Hunter, Stein, & Kaplan, 1989);

- Most adolescents are not sexual predators, nor do they meet the accepted criteria for pedophilia (APA, 2000); and

- Few adolescents appear to have the same long-term tendencies to commit sexual offenses as do some adult offenders (Caldwell, 2007).

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

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

Assessment

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

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

Another type of assessment, that of predicting a youth's risk for future illegal sexual behavior, is significantly more problematic and should be conducted by clinicians with high levels of expertise and a broad knowledge of the literature on risk assessment of adolescents. All professionals need to know that there are *no instruments* that can validly determine whether a particular AISB is at significant risk for future sex offenses (Hunter & Chaffin, 2005). When reporting a youth's level of risk, the report should include specific statements about the limitations on the accuracy of predicting recidivism in AISB. Clinicians should be particularly cautious in making judgments about an adolescent's level of risk because research in this area remains limited.

Treatment

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

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

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

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

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

Ethical Issues

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

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

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

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

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

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

Summary

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

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