

Clinical Article

Adolescent Sexual Offenders: Issues for Pediatricians

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Abstract

The sexual victimization of children by adolescents is a serious problem in our society. Adolescents under the age of 18 years account for 20% of arrests for all sexual offenses (excluding prostitution). Research in this area is limited. Sexually abusive adolescents reside in both urban and rural areas, thereby supporting the need for comprehensive service delivery and a continuum of treatment services to be available in all communities. Pediatricians may get involved during a sexual abuse investigation, and may be called upon to facilitate initial evaluation and coordination of services. Pediatricians who are aware of adolescent sexual offending can increase their ability to detect adolescents who have aberrant or deviant sexual behavior patterns allowing for early referral and intervention. *Int Pediatr.* 2001;16(2).

Key Words: adolescent sexual offender, paraphilia, pedophilia

Introduction

Sexual abuse of children is a critical problem adversely affecting lives of tens of thousands of children worldwide. Pediatricians' vital role in recognition and management of child sexual abuse has been well established. There is a large body of literature on the various aspects of abused children; however, little data are available in the pediatric literature on adolescent sexual offenders, who are involved in sexual abuse of younger children.

Pediatricians may encounter adolescent sexual offender in their practice under several circumstances. Because of serious the psychosocial and legal implications for the offender and his or her family, it is less likely that the offender or the family will voluntarily seek medical attention or advise from their pediatrician. More often the offender will be brought to the pediatrician by appropriate agency in the course of a child abuse investigation. The pediatrician's assistance may be sought in medical and psychological evaluation

or to facilitate further expert or specialized referral as well as to co-ordinate on-going care. A pediatrician may on occasion recognize indirect or non-specific indicators of in adolescent in his or her practice being involved in sexual abuse of younger children. Less frequently, the offender or the family may seek advice from pediatrician regarding sexual behaviors of the adolescent that might be considered by them to be developmentally inappropriate. The pediatrician may also be a witness or expert witness in sexual abuse case involving adolescent offender.

It is recognized that a complete assessment and management of adolescent sexual offenders involve coordinated participation by a number of professionals from various disciplines (e.g. social work, psychology, psychiatry, pediatrics, law) and community and government agencies. However, pediatricians play an essential role in early recognition, medical and psychosocial evaluation, appropriate referral, and coordination and follow up of medical services. More importantly, since there is a high recidivism from current treatment programs for adolescent offenders, prevention is the most important aspect of management where pediatricians can have an impact. There are many comprehensive reviews and monographs on adolescent sexual offenders available for those who specialize in their treatment; this paper seeks to review some practical aspects for the pediatricians including definitions, characteristics, correlates, assessment, treatment and legal issues.

The sexual victimization of children by adolescents has become a serious problem in our society.^{1,2} Adolescents under the age of 18 years account for 20% of arrests for all sexual offenses (excluding prostitution), 20-30% of rape cases, 14% of aggravated sexual assault offenses, and 27% of child sexual homicides.³⁻⁶ About 0.5% of all adolescents are ever arrested for violent crimes of which sexual offending represents a small subset.⁷ Known offenders represent only a fraction of the number of actual cases of child and adolescent sexual abuse.^{5,7} Therefore, the current knowledge of sexual offenses excludes a large number of unidentified offenders and is mainly based on the study of adolescents who have been caught.

Terminology

Familiarity with relevant psychiatric and legal terms is essential to facilitate an understanding of the literature on sexual offending.

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Table 1 - Paraphilias

Exhibitionism: This individual displays or attracts attention to his or her genitals.

Fetishism: These individuals use non-living objects (not a fetish if limited to female clothing used in cross-dressing or devices designed for the purposes of tactile genital stimulation).

Frotteurism: These individuals bump, touch, or rub against others for sexual satisfaction without that person's knowledge or consent.

Sexual Masochism: The perpetrator actually humiliates, beats, binds or otherwise makes his or her victim suffer.

Sexual Sadism: The perpetrator is sexually aroused by the actual psychological or physical suffering he or she causes to his or her victims.

Transvestic Fetishism: This individual is a heterosexual male who cross-dresses and may or may not have persistent discomfort with his gender role or identity.

Voyeurism: These individuals observe another person who is nude, undressing, or engaging in sexual activity without that person's consent or knowledge.

Pedophilia (see Table 2).

Adapted from: National Council of Juvenile and Family Court Judges, *Juvenile and Family Court Journal*. 1993:44(4); American Psychiatric Association. (1994). *Paraphilias - Sexual and Gender Identity Disorders, Diagnostic and Statistical Manual of Mental Disorders* (DSM- IV-TR, 2000). Washington, DC: American Psychiatric Association.

Paraphilias

A significant percentage of reported criminal sexual acts against children are various types of Paraphilias. The psychiatric diagnosis of a Paraphilia involves a set of behaviors characterized by intense sexually arousing urges, fantasies, or behaviors. Paraphilias involve one of the following: a) non human objects; b) suffering or humiliation of oneself or victim; or, c) children or other nonconsenting persons.¹⁰ In order to make a psychiatric diagnosis, these behaviors must have occurred for at least six months and caused distress or impairment that impedes social, occupational, or other important areas of functioning. Paraphilias are classified according to the nature of the sexual act involved and are briefly described in Table 1.^{2,10} The DSM-IV based criteria for Pedophilia are described in Table 2. Sexual sadism and pedophilia are considered the most injurious types of paraphilias and most subject to arrest and incarceration.^{8,9,11} Sodomy is not considered a psychiatric diagnosis.

Table 2 - DSM-IV-Based Criteria for Pedophilia

- Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger). The adolescent should be at least age 16 years and at least 5 years older than the child or children being abused or victimized.
- The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

(Based on: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text-Revised*. 2000. Washington, DC)

Legal Definition

Legal meanings of sexual offenses vary from state to state.^{8,9} However, statutes typically define sexual offenses in terms of: a) penetration offenses, which include penetration of virtually any body orifice for a sexual purpose, and are felonies; and b) crimes not involving physical contact (e.g. voyeurism, exhibitionism, obscene phone calls). Such offenses progress from privacy issues at the misdemeanor level to the felony level, depending on the specific circumstances of each case.^{6,8,9} The addition of physical force or coercion will almost always result in a felony life offense.^{6,8,9}

Characteristics of Adolescent Offenders

A small percentage of adolescent offenders (2-4%) are responsible for most of sexually assaultive behavior committed by adolescents.^{12,13} These adolescent offenders account for the victimization of approximately one-half of boys and one-quarter of girls who are molested or sexually abused. Most of adolescent offenders are males who victimize females. Very little data are available on female sexual offenders.¹⁴ However, when adolescent molesters (male or female) violate very young children, they tend to select male victims.¹⁴⁻¹⁸ Adolescents who abuse young children represent a heterogeneous group, who commit an array of offenses, commit multiple offenses, usually have more than one victim, and may not limit their offenses to one type of victim.^{12,14}

Adolescent sex offenders rarely have previous convictions for sexual assault, but they (63%) are likely to have committed nonsexual offenses.^{3,12} Most incest offenses occur in the victim's home and often when the perpetrator is providing child care services.⁵ Adolescent rapists, on the other hand, tend to victimize strangers.⁷ Offenses commonly include intercourse as the age of both the perpetrator and victim increase.^{5,12,13,17} Adolescent offenders are less

likely than adult offenders to use power and control in the perpetration of their offenses and tend to be less violent.¹⁷ Adolescent sexual offenders (male or female) represent all races, social classes, and regions throughout the United States.¹²

Theories of Etiology

Theories offered to explain the cause of deviant sexual behavior in adolescents toward younger children are primarily based on adult models. The most frequently offered explanations include reconstituted and combined versions of a) Social Learning Theory,^{18,19} b) Developmental Theory,^{20,21} c) Cognitive-Behavior Theory,^{22,23} d) Attachment Theory,²⁴ e) Psychosis Theory,²⁵ f) Addictions Theory,^{26,27} and g) Biological Theory.²⁶⁻³² Three viewpoints are prevalent in the literature: deviant sexual behavior is either learned behavior, caused by biological factors, or caused by a combination of learning and biological factors.^{19,21,27,29,30,33-37}

Unfortunately, most theories do not relate the cause of deviant sexual behavior to other factors that may impair treatment (such as financial, parental, community, or peer resources). Researchers generally agree that there are *multiple* factors (psychological, biological and sociological) that interact in complex and poorly understood ways.²⁶ Studies suggest some association between adolescent sexual offending and a combination of individual characteristics, family variables, and socioeconomic factors.^{14,32} A history of prior physical or sexual abuse, impaired family functioning, alcohol and substance abuse, exposure to erotica, neurobiological factors, and psychiatric comorbidity have been found to be associated with a higher prevalence of adolescent sexual offending.

Prior Abuse

A history of prior abuse is a risk factor for future offending. A significant number of offending adolescents have a childhood history of physical abuse (25-50%) or sexual abuse (10-80%).^{32,38} However, the majority of those abused as a child do not go on to become perpetrators.³² Of particular note is that children and adolescents who have been physically abused were 7.6 times more likely to rape or sodomize other children when compared to adolescents who were sexually abused or neglected.³²

Family Dysfunction

Half of adolescent offenders lived with both parents and one other juvenile at the time of their offending.^{34,39} Families of adolescent sex offenders more closely resemble those of youth with severe emotional or behavioral problems with the following characteristics: a) higher rates of instability

and disorganization;^{39,40} b) members tend to engage in the *denial* of sexual tensions;³⁹ c) members exhibit a paucity of sexual knowledge or education;³⁹ d) mothers exhibit higher rates of neurotic symptoms;^{18,41} and e) parents (25%) have known sexual pathology.⁴¹ Adolescent sexual offenders who had committed sexual homicides experienced exaggerated personal and family dysfunction.⁶

Substance Abuse

Among adolescent sexual offenders, the rates of alcohol and other drug abuse range from 6 to 72% for 30 days prior to the survey.^{30,40,42} Because of such a wide range of prevalence rates reported in different studies it is difficult to draw definitive conclusions as to whether substance abuse is more prevalent among offenders.^{42,43} There is little agreement in the literature as to whether adolescent offenders were frequently intoxicated at the time of offending.^{17,42}

Exposure to Erotica

Some studies suggest an association between exposure to sexually explicit materials and sexually offending behaviors while others do not find such an association.^{30,44} Causal relationships between erotic material and sexual deviance have not been clearly elucidated.^{30,44,45}

Biologic Factors

There is little *consistent* empirical evidence to support biological factors as *direct* causal agents of adolescent sexual offending. Adult studies of the effects of anti-androgens, the luteinizing hormone-releasing hormone (LHRH) antagonists and serotonergics, have looked at the impact these agents have had on sexual offending;⁴⁶ few studies have focused on adolescents.^{37,47,48} High levels of androgens are theorized to contribute to increased libido in adult males; similar data in adolescents are not known.⁴⁶⁻⁴⁸

Comorbid Disorders

Several studies have reported a higher prevalence of comorbid psychiatric disorders in their adolescent sexual offenders when compared to non-sexual offending and non-delinquent adolescents.^{39,49,50,51} The most common psychosocial deficits adolescent sexual offenders are likely to include: low self-esteem, few social skills, minimal assertive skills, and poor academic performance.^{5,6,37,52-55} The most common psychiatric diagnosis is conduct disorder followed by substance abuse disorders, adjustment disorders, attention-deficit/hyperactivity disorder with hyperactivity, specific phobia, and mood disorders.^{17,38,50,56} Male offenders are more often diagnosed with paraphilias and antisocial be-

havior, while female offenders are more likely to be diagnosed with mood disorders and engage in self mutilation.¹⁴

Adolescent offenders have fewer behavioral problems than their non-sexual offending delinquent peers.⁵⁰ No significant differences are found regarding intellectual or psychological capabilities when juvenile sex offenders are compared to other violent and nonviolent adolescent offenders.³⁴ Similar to other delinquents, adolescent sexual offenders frequently engage in distorted thinking to make their offenses more socially acceptable to themselves and others.^{50,56,57} A more severely disturbed group of adolescent offenders are those who commit child sexual homicides (less than 1% of the total number of murders committed by juveniles).⁵⁸ These offenders often experience violent sexual fantasies before committing their crimes.^{5,6,52,57}

Legal Issues

As the pediatrician attempts to determine whether a reported sexual act represents normal or exploitative sex play, the developmental maturity of the offender as well as the victim must be considered. In most juvenile justice jurisdictions it is unimportant whether the alleged victim has consented to the act or is an involuntary participant.⁸ Specific provisions in many statutes provide that the inability of the victim to consent is an element of the degree of the offense, helping to define the severity of the punishment. If an individual cannot consent, such as with young children and individuals with mental retardation, the offense is more serious.⁸ For example, mental deficiency or the young age of the victim may define a sexual crime as a "life felony offense" as opposed to a "misdemeanor offense."

Sexual offenses only become a legal problem for offenders when they are brought to the attention of authorities. However, few adolescents are caught or prosecuted and those offenders who are arrested and convicted often receive minimal punishments (probation, community service).^{11,34,58} Once there is sufficient evidence to identify an offender, a decision regarding prosecution is often made at the juvenile court level. Trials in the juvenile justice system are less formal and are often conducted in private without the use of a jury. Juveniles in this system are more likely to receive efforts at rehabilitation and less likely to be held fully accountable for their actions, than if they were adjudicated in the adult courts. However, in the case of rape, sodomy or sexual homicide, most states have moved to address adolescent offending in the adult criminal justice system, which can impose harsher punishments.^{8,11,59,60}

The age at which an adolescent can be adjudicated for criminal behavior varies. The minimum ages in those jurisdictions where age is defined varies from 6 to 12, with most states setting 10 years as the lowest age of criminal responsibility.^{8,9,59,60} Many states have enacted legislation allowing

the juvenile court to "waive" jurisdiction to the adult court based upon the severity and nature of the crime. For example, a juvenile court may waive jurisdiction for a 14-year-old accused of a heinous crime and turn it over to the adult court for prosecution. Such a waiver is discretionary, and in some instances, a hearing is held before such a determination is made.^{11,52}

Local statutes usually govern physician-patient privileges (i.e. the right to respect the confidentiality of all communications). Thus, the development of such privileges in each state is subject to local interpretation and state-by-state case law developments. Pediatricians should explain, at the outset, to all adolescents and their families the limits of confidentiality. As guided by local laws and standards of medical practice, certain acts that are harmful to the adolescent or others will have to be reported to appropriate agencies. If the adolescent's behavior must be reported to the authorities or potential victims warned, the pediatrician should inform the adolescent and the family. This may cause considerable distress on their part and the pediatrician, and though sensitive to their feelings the pediatrician nevertheless should inform them of his or her duty.

Reporting any crime changes the status of the act from private to criminal. Most pediatricians are familiar with local child abuse reporting laws and procedures. In every state the definition of child abuse is not left to the determination of the professional; thus, professionals who deal with children, have an enforceable mandate to report suspected child abuse.^{8,59} All fifty states have "mandated reporting" laws which require professionals to report "reasonable suspicions" that abuse or neglect has occurred.⁵⁹ Professional obligations pertaining to confidentiality may be seriously challenged by the requirements of the law and the local community, particularly when it involves sexual conduct.⁵⁹

Assessment

The pediatrician is concerned mainly with medical and psychosocial assessment of the adolescent offender, and is not expected to conduct a specialized or forensic evaluation. Such an assessment consists of a history of the offending incident, psychosocial history, medical history, and a physical and neurological examination. The extent of evaluation done by the pediatrician may depend up on his or her experience and familiarity with such cases. In most cases the pediatrician may elect to refer the adolescent to a colleague with more expertise in this area. The specialized assessment is best done by professionals trained to conduct such evaluations of adolescent sexual perpetrators.^{11,14}

Most pediatricians will become involved in sexual offending cases during discovery (when offense is first reported to professionals). This makes it essential to carefully document who reported what information. It is generally neither necessary nor advisable for the pediatrician to go

into finer details of the incident; however, enough information should be obtained to justify that an offense has occurred. Detailed investigation is best left to the authorities.

It is often difficult to ask an adolescent if he or she is a perpetrator of sexual or physical abuse. The pediatrician who discovers such behavior is generally required by law to report such incidents to appropriate agencies. After the limits of confidentiality and "Duty to Warn" have been explained, pediatricians should obtain sexual behavior history of the adolescent in order to identify deviant behaviors.^{59,61,62} Adolescent sexual offenders commonly deny the act and the responsibility of their crime by attributing the "idea" or intent to something or someone else.^{45,61} Adolescent offenders may admit that the sexual act was wrong but deny any personal responsibility.^{63,64} Some offenders will say they were in control, admit that it was their idea, but attribute causality to extenuating circumstances.^{11,35,44,61}

Rarely does the adolescent or the parent voluntarily reveal that a sexual perpetration has occurred. The evaluation often centers on other psychosocial or physical complaints. The pediatrician can, in the course of a routine evaluation, ask adolescents questions about peer relationships, interactions with younger children, and the nature of those interactions to obtain information regarding potential risk factors for sexual offending.

An evaluation may begin by determining if the adolescents have younger children living in their home and the social relationship they have with them. Ask about peer relationships, extracurricular activities, and social isolation, in addition to sexual interests, fantasies, sexual activity and expression. If responses indicate sexual behavior or fantasies, explore the nature and content of that behavior. If the others involved in the sexual acts are younger than the patient is, ask about differences in the ages, how the sexual contact takes place, and the persistence of the activity. This information is helpful in determining if the behavior falls under sexual experimentation or exploitation.

Determining whether an adolescent has committed sexually *deviant* behavior becomes clouded when the question of *normal* versus *exploitative* sexual activity arises. Since there are no clear definitions of normal sexual experimentation between children or adolescents, it is sometimes difficult to differentiate between the two.¹⁵ Table 3 provides a list of questions that pediatricians can ask adolescents to help make this determination.

Treatment

Up on initial assessment the pediatrician can provide some basic guidance to the adolescent and his or her parents. If the "sex play" is determined to be experimental or exploratory, the pediatrician should discuss normal childhood and adolescent sexual behavior with parents and outline measures to minimize inappropriate sexual stimulation

Table 3 - Distinguishing Sexual Exploitation

1. What is the age difference between the participants?
If the children are not peers in terms of age or cognitive level, exploitation is likely.
2. Is the activity consistent with the developmental level of the participants?
Pre-pubertal exploratory behavior typically involves mutual genital display, touching, and fondling; intercourse or attempted intercourse is atypical among preschoolers and is rare in the young school-aged child (6 - 9 years).
3. What is the motivation of the participants?
Young children are motivated to exploratory behavior by curiosity about differences and similarities in anatomy and pleasurable feelings associated with masturbation. The older child adds interest in sexual roles and sexual identity to the curiosity and pleasure motivations. Participants who are not mutually motivated by these factors may be involved in exploitative sexual contact.
4. Is the activity consensual or coercive?
Mutual consent is typical of exploratory behaviors. Abusive behavior often involves elements of pressure, misrepresentation, force, threat, secrecy, or other forms of coercion. Although some of the threat or coercion is obvious and violent, the evaluator must take care to recognize subtle emotional pressure or the use of implied authority by an older child or adolescent in some cases.
5. Is there an outside influence involved?
Two children or adolescents may be involved in age-appropriate exploratory behavior, but if the contact has been arranged for the pleasure of another older individual, it is exploitative.
6. What is the response of the child to the contact?
Mutual exploratory behavior may engender some guilt feelings in children; however, feelings of anger, fear, sadness, or other strongly negative responses are unusual. Exploitation is more often viewed in negative terms by the child; however, some abused children will appear to have a neutral or positive emotional response to abuse. The victims' denial may mask the negative responses in some cases, or the child's emo-

in the home. Parents should be advised to provide closer supervision of the adolescent. Older adolescents can be instructed to stay away from compromising situations with younger children. If the sexual behavior is determined to be exploitation, in addition to the preceding suggestions, medical examination and documentation should be performed and as required by state child abuse laws the family should be referred to the appropriate agency for further evaluation. If the adolescent has access to other children, especially very young, the pediatrician should assess the level of risk posed to those children. If it is determined that the child or adolescent is at high risk for sexually assaulting those children, the pediatrician should inform the family and appropriate persons. Furthermore, the family should be advised to stop all baby-sitting and childcare activities to limit the adolescent offender's opportunity to re-offend. A more definitive treatment may not be within the purview of all pediatricians and generally adolescent offender will be referred to professionals and programs specializing in such treatment.

The treatment of adolescent sexual offenders remains controversial.⁶³⁻⁷¹ Many of the treatment interventions have not been scientifically evaluated on adolescents; instead, they have been adapted from experience with adult sexual offenders. Most treatment programs focus on rehabilitation of adolescent offenders in the private sector and on the prevention of re-offending.^{4,19,45,46,51,63} Few studies have looked at the efficacy of treating adolescent sexual offenders by setting (forensic vs residential vs. community), or method of treatment; of the studies that addressed treatment efficacy, each concluded that their intervention was effective regardless of the setting.^{4,14,21,30,37,47}

Most studies employed interventions designed to address a multitude of deviant behaviors. Each intervention program was re-designed for use with adolescents by adding components to address developmental issues. These programs typically included several treatment modalities, such as individual, family and group formats, biological therapy, substance abuse interventions, cultural sensitivity training, victim empathy training and protection, cognitive restructuring, values clarification, consideration of victimization issues, anger management, social skills training, assertiveness training, problem-solving skills training, grief counseling, stress management, peer counseling, sex education, and covert sensitization. Several other less frequently employed interventions of verbal satiation, polygraph, systematic desensitization and relapse prevention training have also been reported.^{4,21,35-37,63-65,69} Unfortunately, there remains little empirical evidence of the long-term effects of different intervention with adolescent sexual offenders.

The most controversial treatment methods include: arousal assessment (plethysmograph), aversion therapies (noxious odors or electric shock), anti-hormonal therapy (e.g. anti-androgens and medroxyprogesterone acetate), chemical castration (e.g. luteinizing hormone-releasing hormone [LHRH]), truth assessment (polygraph used to verify self-report data) and fluoxetine to control a-sexual fantasies.^{4,30,35,36,47,54,55,68} Issues surrounding informed consent and the intrusiveness of these procedures are not well researched with adults and are even less so with adolescents.^{35,66,70} Most researchers based outcome data on rates of recidivism, self-report, family and clinician reports of levels of arousal, and repeat offending.^{63,72} Evidence suggests short-term benefits of some treatment modalities with adolescents, but long term recidivism rates remain high.^{51,72} It is essential that additional well-controlled research with different techniques be conducted specifically designed for adolescent offenders. Insufficient research on outcome data make it difficult to justify, at this time, the development of special treatment programs for adolescent sexual offenders versus other types of juvenile delinquents.⁶⁶

Conclusion

Adolescent sexual offenders represent a serious problem in our society. They commit multiple offenses, usually have more than one victim, and may not limit their offenses to one type of victim. These adolescents represent all races, social classes, and regions throughout the United States. This supports the need for comprehensive service delivery and the importance of having a continuum of treatment services that are available in all communities. Within the context of anticipatory guidance pediatricians can incorporate office-screening questions regarding sexually deviant behaviors to detect aberrant or deviant sexual behavior, allowing for early referral and intervention. They can play a role in education parents about the importance of seeking appropriate professional help for deviant sexual behavior in children and adolescents. Our greatest hope of addressing this problem remains *prevention* and further research into this often neglected area.

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