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Developmental risk factors of juvenile sex offenders by victim age: An implication for specialized treatment programs

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ABSTRACT

Specialized treatment programs exist for juvenile sex offenders (JSOs) on the basis that JSOs are a homogeneous group. However, several studies have shown support for the heterogeneity of JSOs on the observed differences in victim age preferences within this group; those that offend against children (child molesters), and those that offend against peers or adults (peer abusers). To better meet the individual needs of treatment and rehabilitation, there must be an understanding of the developmental risk factors associated with each sub-type of JSOs. This paper reviewed 13 published studies on the differences in developmental risk factors between juvenile child molesters and peer abusers. The review found that child abusers were more likely to be submissive, have lower self-esteem and to show internalizing behaviour problems, whereas peer abusers were more aggressive, anti-social and were more likely to show externalizing behaviour problems. Although inconsistencies in results were observed across some studies, the results from this review suggest the need to separate JSO treatment approaches depending on victim age preference. Child molesters may benefit more from individual-based treatment programs (i.e. cognitive behavioural therapy) whereas peer abusers may benefit from a community-based approach to treatment such as multi-systematic therapy.

1. Introduction

Juvenile sex offenders (JSOs) represent a significant portion of the overall sex offender population (Joyal, Carpentier, & Martin, 2016). They are defined as those who commit sexual offenses and are at least 12 years of age, but under the age of 18. Numerous studies show supportive evidence for the success of specialized assessment and treatment programs for JSOs through recidivism and sexual deviance measures (Fanniff & Becker, 2006; Reitzel & Carbonell, 2006; Worling & Curwen, 2000). However, future modifications to the current treatment approach has been suggested. JSOs are a heterogeneous group with the existence of sub-groups within this population (Righthand & Welch, 2004; Seto & Lalumière, 2010; van Wijk et al., 2006) but were often treated as a homogeneous group (Lambie & Seymour, 2006). It would thus be beneficial to match individuals or sub-groups of JSOs to specialized treatment programs based on individual needs. It is essential to first gain a deeper understanding of the developmental risk factors associated with each sub-groups of JSOs.

JSO treatment programs follow approaches similar to that of adult sex offenders (Lambie & Seymour, 2006). Treatment programs aim to treat deviant sexual arousal, impulsive control and judgement, social skills, and distorted cognition and aggression (Prisco, 2015). The most common intervention approaches are multisystematic therapy (MST) and cognitive behavioural therapy (CBT). A specialized form of the standard MST for juvenile sex offenders is the multisystematic therapy for problem sexual behaviours (MST-PSB), and is a family and community-based intervention program (Borduin & Dopp, 2015). This form of treatment involves not just the individual, but interventions at the family, community and peer levels as well. Family level intervention is aimed to assist in parental monitoring, communication, and affection toward their children, as well as to educate caregivers in effective risk reduction techniques. Community interventions involve teachers and schools, and caregivers are encouraged to communicate with those involved in the youths' academic environment. At the peer level, caregivers are guided to encourage youths' association with non-delinquent peers and to support in developing relationship and social skills. CBT is focused mainly on intervention at the individual level and aim to restructure cognitive distortions, which is a term that refers to negative automatic thoughts and beliefs that influence deviant sexual behaviours (Moster, Wnuk, & Jeglic, 2008; Ward, Hudson, Johnston, & Marshall, 1997). CBT has been shown to be successful in improving self-esteem, overall behavioural problems and social skills in juvenile offenders (Redondo, Martínez-Catena, & Andrés-Pueyo, 2012).

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The identification of sub-groups within the population of JSOs is important not only for identifying etiological pathways to sex offending, but also for rehabilitation and treatment purposes. Two main typologies have been proposed for JSOs. The first typology is based on criminal history and the other on victim age preference. Sex offenders who also commit non-sexual offenses are often referred to as sex-plus offenders, and are distinguished from those who only commit sexual offenses, or otherwise called sex-only offenders (Butler & Seto, 2002; van Wijk, Mali, & Bullens, 2007). JSOs can also be categorized according to the preference of victim age, where offenders may target either pre-pubescent children or peers and adults (Keelan & Fremouw, 2013; Seto & Lalumière, 2010). Offenders that target younger children are generally referred to as child molesters and those that target peers as peer abusers. Distinctive characteristics were observed for the victim-age typology, such as differences in behavioural problems and socio-economic factors (Aebi, Vogt, Plattner, Steinhausen, & Bessler, 2012; Leroux, Pullman, Motayne, & Seto, 2016).

The treatment of offenders is important for the protection and safety of the community as a whole, as well as in assisting offenders re-integrate into the community (Prisco, 2015). This is especially important for the adolescent population. Treatment programs should aim to reduce characteristics that are specific to each individual (Eastman, 2005) such as psychopathologic symptoms that may be observed for those with conduct or mood disorders. Recidivism studies have shown inconsistent rates amongst the sub-types of JSOs (Keelan & Fremouw, 2013). This may be a result of the generalized treatment approach to JSOs. Given that treatment programs exist for JSOs, resources should be allocated in such a way to increase the efficiency of the overall effectiveness of these programs. This paper reviewed the current literature on the differences in developmental risk factors between juvenile child molesters and peer abusers.

2. Method

Studies that measured for developmental risk factors of JSOs were searched in the following electronic databases: Academic Search Complete, Google Scholar, Sage Knowledge, Science Direct, SpringerLink, Taylor & Francis Online, and Web of Science. Combinations of the following key terms were used for the search: “juvenile sex offenders”, “adolescent sex offenders”, “victim age”, “typology”, “offender type”, “classification”, “child molesters”, “child abusers”, “peer abusers”, “rapists”, “development”, “risk factor”, “comparison”, “subgroups” and “characteristics”. The search was conducted on all articles published from 1990 to 2016. Only empirical studies (studies that collected and analyzed raw data) were included in this review. Any studies that did not make the distinction between juvenile child molesters and juvenile peer abusers were excluded from the review. Furthermore, any literature that did not measure for developmental risk factors, or conducted in languages other than English were excluded. Only male offenders were included in these studies due to the limited number of female offenders, if any.

2.1. Risk factor domains

Risk factors were categorized into three main domains—individual, family, and peer. The domains were specifically chosen to match the general domains that are targeted for treatment in MST-PSB, as described above (Borduin & Dopp, 2015). The individual risk factors were further categorized into four sub-domains: mental health, psychosocial traits, personality traits, and cognitive abilities.

The mental health sub-domain included all findings related to previously diagnosed psychiatric disorders. Interpersonal traits were characteristics of individuals related to their mental well-being in relation to psychosocial aspects, but those that were not specified to any disorders. This sub-domain included variables that measured for characteristics such as low self-esteem, dysphoria, and social isolation. The personality traits sub-domain included behaviour measures such as antisocial attitudes and undiagnosed internalization or externalization behaviour problems. Oppositional defiant disorder and conduct disorder were treated as a measure for antisocial behaviour. Oppositional defiant disorder is diagnosed when children exhibit patterns of anger, irritated mood or defiant behaviour for at least a period of six months. Conduct disorder is similar to oppositional defiant disorder in that it is diagnosed in children who show defiant behaviour, but also includes those that violate societal norms or the basic rights of others. Although conduct disorder is a diagnostic mental disorder that is included in the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-V), not all children who are diagnosed with this disorder follow the developmental trajectory into antisocial personality disorder. There have been disagreements on the validity of personality disorder diagnosis in adolescence, where personality is still in development up until adulthood (Adshead, Brodrick, Preston, & Deshpande, 2012). Furthermore, the diagnostic criteria of personality disorders are heavily based on observable behavioural symptoms. Thus, behavioural measures of oppositional defiant disorder and conduct disorders were categorized in the sub-domain of personality traits and treated as a measure for antisocial behaviour rather than as a mental disorder. Measures for attention deficit hyperactivity disorder (ADHD) were treated as externalizing behaviour, as the diagnosis of ADHD is dependent on certain characteristic behaviour patterns that lead to problems in their everyday life, largely in social settings (American Psychiatric Association, 2013). Measures for deviant sexual interests were also included in the personality traits sub-domain. Finally, the sub-domain of cognitive abilities included factors that measured for intellectual functioning such as intelligence test scores.

The family domain consisted of two sub-domains of childhood history and family characteristics. Childhood history was focused mainly on childhood sexual abuse histories. This risk factor was included under the family domain since less than 20% are victimized by offenders who are unknown to the victim (Finkelhor, 2009). Family characteristics were factors such as family income, parental supervision, criminal history of family members and witnessing domestic violence. The peer domain encompassed variables such as being a victim of bullying, peer relationships, and associations with delinquent peers.

3. Results

A total of 13 empirical studies were found on developmental risk factors of juvenile child molesters and peer abusers, from the years 1990 to 2016 (Table 1). The reviewed studies were conducted in Belgium (Glowacz & Born, 2013), Canada (Joyal et al., 2016; Leroux et al., 2016; Worling, 2001), the Netherlands (Hendriks & Bijleveld, 2004; van Wijk et al., 2005), Switzerland (Aebi et al., 2012), the United Kingdom (Gunby & Woodhams, 2010) and the United States (Fanniff & Kolko, 2012; Hsu & Starzynski, 1990; Hunter, Figueredo, Malamuth, & Becker, 2003; van der Put & Asscher, 2015). One study did not specify the exact location of study (Kempton & Forehand, 1992). It must also be noted that data from Hendriks and Bijleveld's (2004) study was also included in van Wijk et al. (2005). Two extra studies were cited by van Wijk et al. (2005) that showed evidence of juvenile child molesters exhibiting more social isolation compared to peer abusers; however, the original articles were written in Dutch, and thus was excluded from this review.

The mean sample size of juvenile child molesters for the 13 studies was 95 (SD = 94) with the range of 8 (Kempton & Forehand, 1992) to 341(van der Put & Asscher, 2015). The mean sample size was 59 (SD = 56) for peer abusers with a range of 7 (Kempton & Forehand, 1992) to 57 (van der Put & Asscher, 2015). The total mean sample size for the entire JSO population in the studies was 154 (SD = 143) with the range of 15 (Kempton & Forehand, 1992) to 548 (van der Put & Asscher, 2015). The age of the offenders included in the 13 studies ranged from 10 to 19 years. One study did not specify the exact range of the offenders' age, but clearly stated the definition of child