

What Do We Know About Evaluating and Treating Female Adolescent Sex Offenders?: An Overview of the Literature



American Society for Adolescent Psychiatry
2008 Annual Meeting
Boston, MA
March 27, 2008

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Disclaimer - General

This presentation was developed as an overview of evaluation and treatment of adolescent females with sexual offending and problem behaviors. The emphasis is on material relevant to mental health care clinicians, who might be tasked with conducting initial evaluations and treatment planning of adolescent females with sexual offending histories. The content was selected to provide an overview in the allotted time rather than all inclusive coverage, but with resources to enable participants to further their practical understanding of adolescent female sexual offending.

Disclaimer

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Financial Disclosure

Neither of the presenters or their spouses have had a relevant financial relationship in the past twelve months with proprietary entities producing health care goods or services presented herein.

Disclosure of Off-Label Use

All use of prescription medications for the treatment of sexually aggressive, sexual offending, and paraphilic behaviors in the United States is off-label use, meaning it is not approved by the United States Food and Drug Administration for that use.

Learning Objectives

Presentation participants will be able to:

1. identify the prevalence of known sexual offending by adolescent females;
2. understand the content of a comprehensive protocol for assessing treatment needs for and estimating risk of sexual re-offending by adolescent females;
3. identify the evidence-based psychological treatment options available for adolescent female sex offenders;
4. recognize biological options for treating sexual offending behavior by adolescent females.

Prevalence

Sexual Offending Definition

Arrest Data

Victimization Data

Sex Offense Defined

- Purposeful act
- Sexual act
- Against another
- May include physical, verbal or other form of coercion or manipulation

(based on American Psychiatric Association Task Force definition; APA, 1999)

Arrests

United States, 2006

- **Forcible Rape* Arrests**
 - Total: 17,112
 - Female: 224 (1.3%)

- **Sex Offenses*, except forcible rape and prostitution**
 - Total: 63,243
 - Female: 5,508 (8.7%)

(*Offense charged; USDOJ, 2007)

Forcible Rape Arrests United States, 2006

<u>Age in years</u>	<u>Male</u>	<u>Female</u>	<u>All</u>
• 18:	850	8	858
• 17:	603	7	610
• 16:	545	15	560
• 15:	427	6	433
• 13-14:	685	15	700
• 10-12:	197	6	203
• <10:	12	1	13

(USDOJ, 2007)

Sex Offenses*

United States, 2006

<u>Age in years</u>	<u>Male</u>	<u>Female</u>	<u>All</u>
• 18:	2,109	312	2,421
• 17:	1,773	184	1,957
• 16:	1,814	210	2,024
• 15:	1,824	244	2,068
• 13-14:	3,375	335	3,710
• 10-12:	1,349	123	1,472
• <10:	248	37	285

(*except forcible rape & prostitution; USDOJ, 2007)

Low Rates

- Only reported crimes
- Only arrests
- Social response, when reported

(Bumby & Bumby, 2004)

Adolescent Psychosexual Development

“Normal”
(Healthy)

Adolescents

- Represent a heterogeneous population
- Developmental lines (e.g., physical, psychological, moral, sexual) are not in sync
- Sexual interests and patterns of sexual arousal are not fixed

(Veneziano & Veneziano, 2002)

Early Adolescence

- ↑ “curiosity and concern” about own body, appearance, and self-image
- ↑ Sexual fantasies
- ↑ Masturbation
- Sometimes “shame and guilt” in the adolescent
- Sometimes “discomfort and anxiety” in adults

(Saleh & Vincent, 2004)

Middle Adolescence

- ↑ “sexual energy”
- Casual relationships
 - Coital and non-coital
 - Can be exploratory, promiscuous, exploitive
- Denial of risk – pregnancy and STDs
- Balance personal needs with daily “demands”

(Saleh & Vincent, 2004)

Late Adolescence

- Physical maturation complete
- Sexual Behavior
 - More expressive
 - Less exploitive
 - More sharing
- “Stable psychosocial identity”
- Moral/ethical standards
- Social network to support independence from caregivers

Adolescent Psychosexual Development

“Pathology”
(Unhealthy)

Developmental Continuum

- Normalcy.....Deviancy
- Inappropriate \neq predict sexual offending
- No clear line between normal and pathological

- Previously obedient children can become rebellious and emotionally labile
- Reckless and acting-out behavior is not uncommon
- Adolescents may engage in inappropriate sexual behaviors

Sources of Unhealthy Behaviors

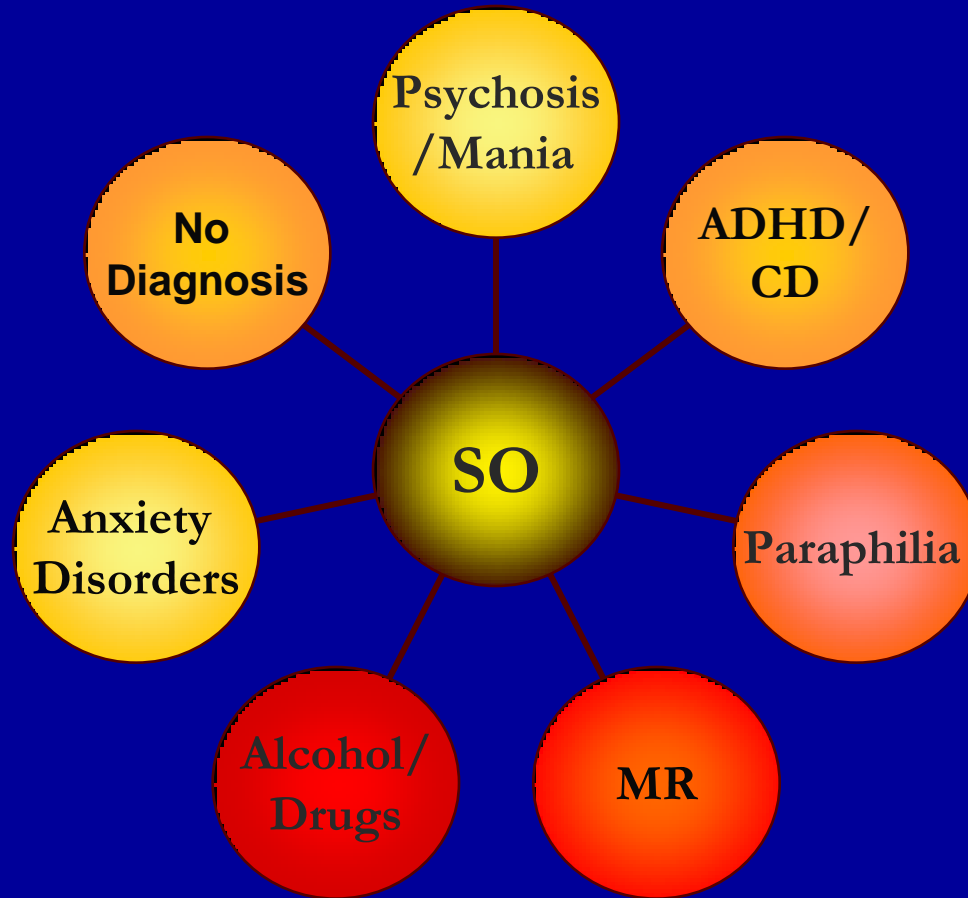
- Reactive
 - Behavioral modeling
 - Premature sexualization
- Pervasive conduct problems
- Interpersonal relationship deficits
- Wide range impairment → opportunistic (isolated and time-limited)

Biological + Psychosocial

- Biological
 - Neurotransmitters
 - Sex hormones
 - Other substrates
- Psychosocial
 - Sexual abuse
 - Home environment
 - Other

Etiology

- Unknown
- Psychodynamic/Behavioral/Cognitive
- Personality Disorders
- Substance Use
- Mania
- Head Trauma/Dementia
- Developmental Delay/Mental Retardation
- Psychosis
- Paraphilia



**Sexual Offending
Etiologies**

Etiologies for Juveniles Summary

- Primarily “global patterns of conduct problems”
- Usually not paraphilias
- Some have no “recognizable pathological condition”

(Saleh & Vincent, 2004)

Characteristics

Offenders

Victims

Offenses

Offenders General

- **Heterogeneous** (Bumby & Bumby, 2004; Mathews et al, 1997)
- **Abuse victims** (Hunter et al, 2006; Mathews et al, 1997; Tardif et al, 2005)
 - **Sexual abuse victims** (Bumby & Bumby, 2004; Lane & Lobanov-Rostovsky, 1997; Mathews et al, 1997; Tardif et al, 2005)
 - **Most abuse victims do not become perpetrators** (Caswell & Caruso, 1997; Martin & Pruett, 1998; Shaw, 1999)
- **Witness violence** (Hunter et al, 2006; Mathews et al, 1997)
- **Chaotic childhood/family environment** (Ford, 2006; Hunter et al, 2006; Mathews et al, 1997)

Offenders

Psychiatric Co-Morbidities

- **ADHD** (Hunter et al, 2006; Tardif et al, 2005)
- **Anxiety** (Mathews et al, 1997)
- **Borderline Personality Disorder** (Hunter et al, 2006)
- **Conduct Disorder** (Hunter et al, 2006; Tardif et al, 2005)
- **Depression** (Hunter et al, 2006; Mathews et al, 1997)
- **PTSD** (Hunter et al, 2006; Mathews et al, 1997; Tardif et al, 2005)
- **Schizoaffective** (Hunter et al, 2006)

Offenders - School History and Socioeconomic Status

- Not consistently reported in published studies
- Not always clearly defined
- Contradictory reports
- Not likely a discriminating factor given currently available data

Victims

- Younger than offenders (Bumby & Bumby, 2004; Hunter et al, 2006; Mathews et al, 1997; Tardif et al, 2005)
 - 69% of offenses against victims under six years old (Rich, 2003)
- Male and female (Bumby & Bumby, 2004; Ford, 2006; Lane & Lobanov-Rostovsky, 1997; Mathews et al, 1997; Tardif et al, 2005)
- Known to offender (Bumby & Bumby, 2004; Lane & Lobanov-Rostovsky, 1997; Mathews et al, 1997; Tardif et al, 2005)
 - During babysitting (Bumby & Bumby, 2004; Hunter et al, 2006; Mathews et al, 1997; Tardif et al, 2005)

Offenses

- **Same as males** (Ford, 2006; Hunter et al, 2006; Lane & Lobanov-Rostovsky, 1997; Mathews et al, 1997)
 - Hands-on
 - Hands-off
- **Use/threat of force, but less than males** (Bumby & Bumby, 2004; Ford, 2006; Mathews et al, 1997)
- **Usually alone** (Hunter et al, 2006)
- **Single victim; multiple victims** (Hunter et al, 2006)

Initial Evaluation

Background Data, Clinical Interview,
Screening Instruments, Lab Testing
and Physiological Assessment

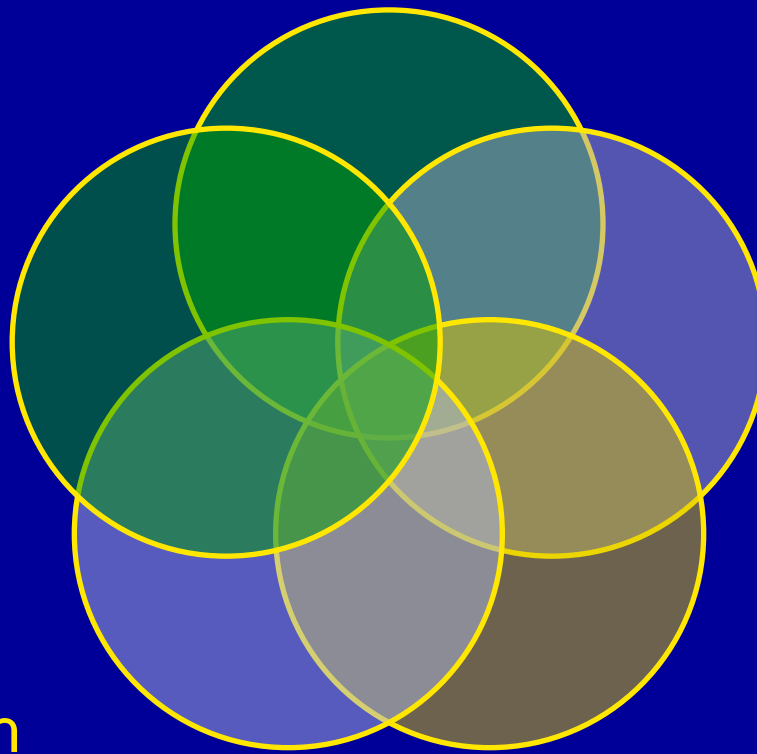
Developmental/Family
Histories

Criminal
Justice

General
Medical

Mental Health

Education
Employment
Social



Guidelines

- National/international associations
- Individual state requirements/guidelines
- Individual experts
- Advantages/disadvantages to each

Reasons for Evaluation

- Treatment planning
- Risk assessment
- Management level determination
(Saleh & Vincent, 2004; Lane, 1997)
- Non-sexual offending issues may need to be addressed as well
(Hunter et al, 2006; Lane, 1997)

Assessment is Ongoing

- Throughout the treatment process
- Less than honest responses during pre-adjudication and at start of treatment are likely
 - Fear
 - Embarrassment
 - Misguided advice
 - Other factors
 - Multifactorial

(Lane, 1997)

Consent

- Prior to start of assessment
- Signed by client to be interviewed
- Signed by parent/guardian of the client

(Lane, 1997; Shaw et al, 1999)

Developmental History

- **Pregnancy**
 - Infection
 - Trauma
 - Medication use
 - Substance use
- **Milestones – when**

(Hunter et al, 2006; Lane, 1997)
- **Family interactions**
- **Peer relationships**
- **Birth**
 - Complications
 - APGAR scores

(Lane, 1997; Shaw et al, 1999)

General Medical

- Identify general medical diagnosis
- Level of sexual maturity (Saleh & Vincent, 2004)
- Sexually transmitted disease (Shaw et al, 1999)
- Identify or rule out general medical causes of psychiatric symptoms and sexually inappropriate behavior

Screening Labs

- Infection
- Anemia
- Liver disease
- Thyroid disease
- Parathyroid disease
(Saleh & Vincent, 2004; Saleh, 2005)
- Electrolyte and mineral imbalance
- Sex hormones
(Saleh, 2005)

Other General Medical Diagnostic Assessments

- Neuroimaging of the brain
- Electroencephalogram

(Saleh & Vincent, 2004)

School History

- Cognitive ability
- Academic performance
- Sources
 - School records such as grade reports
 - Psychological testing

(Shaw et al, 1999)

Family Functioning

- Parents' psychosocial histories
- Disciplinary methods
- Nature and degree of support
- Extent and quality of displays of:
 - Affection
 - Aggression
 - Love
 - Sexuality

(Lane, 1997; Shaw et al, 1999)

Psychiatric Data

- Psychiatric History

(Shaw et al, 1999)

- Diagnosis
- Treatment
- Medications
- Hospitalization

- Psychopathology

(Shaw et al, 1999)

Victimization History

- Physical abuse
- Neglect

(Lane, 1997; Shaw et al, 1999)

- Sexual abuse
- Exposure to sexually inappropriate activity

(Lane, 1997; Saunders & Awad, 1988; Shaw et al, 1999)

Sexual History

- Sexual knowledge
- Gender identity
- Sexual orientation
- Sexual self-perception
- Genital anomalies
- Genital injury
- Sexual experience

(Lane, 1997)

Sexual Experience

- **Dating** (Lane, 1997; Saunders & Awad, 1988; Shaw et al, 1999)
- **Kissing**
- **Petting**
- **Masturbation**
- **Intercourse** (Lane, 1997; Saunders & Awad, 1988)
- **“Homoerotic experiences”**
- **Pornography**
 - Exposure to
 - Use(Lane, 1997; Saunders & Awad, 1988)
- **Fetishes** (Lane, 1997)

Sexual Aggression

- Past incidents
- Patterns
- Range of behaviors
- Victim profile
- Internal triggers
- External triggers
- Use of aggression
- Use of sadism
- Domination
- Humiliation

(Lane, 1997; Shaw et al, 1999)

(Shaw et al, 1999)

Sexual Compulsions

- Identify them
- Distinguish between:
 - “Normal”
 - Paraphilic

(Shaw et al, 1999)

“Deviant” Behaviors

- Duration
- Frequency/recency
- Number and variety of “deviant” behaviors
- Grooming behavior
- Specific factors that place individual at risk for offending

Criminal History

- Non-sexual delinquent behavior
- Arrests
- Convictions
- Incarcerations
- Use of a weapon
- Animal cruelty

(Shaw et al, 1999)

Information Sources

- Clinical interview of the client - **Critical**

(Shaw et al, 1999)

- Psychological assessments

(Lane, 1997; Shaw et al, 1999)

- Prior evaluation results

- Interviews
- Assessment data
- Final reports

Information Sources

(continued)

- Police reports

(Coric et al, 2005)

- Victim statements

(Lane, 1997)

- Protective Service reports

- Probation reports

et al, 1999)

(Shaw

- Corrections records

- Court records

- Hospital records

- School records

(Lane, 1997)

- Medical records

(Lane, 1997; Shaw et al, 1999)

Possible Informants

- Teachers
- Prior therapist
- Personal physician
- Victim*
 - At the victim's discretion
 - Directly or through victim's therapist

Psychological Tests

Nothing to definitively diagnosis sexual offending

- Intellectual functioning
- Defense mechanisms
- Personality traits
- Motivators
- Psychopathology
- Sexual knowledge
- Sexual behaviors
- Depression
- Anxiety
- Sexual functioning
- Paraphilias
- Anger control
- Empathy
- Attachment
- Self-esteem

(Shaw et al, 1999)

(Lane, 1997)

Sexual Behavior-Specific Instruments

- Multiphasic Sex Inventory
- Adolescent Cognition Scale for Juvenile Sex Offenders
- Adolescent Interest Card Sort
- Child Sexual Behavior Inventory

(Shaw et al, 1999)

Risk Assessment

- Understand offending behavior
- Understand how behavior developed and occurred
- Predict if behavior will continue or reoccur
- Make treatment recommendations

Risk Assessment

- Static - unchanging risk factors
 - Historical facts
- Dynamic - changeable risk factors
 - *Stable* (change over months, years – substance dependence)
 - *Acute* (change over minutes, days, weeks - intoxication, victim access)

Sexual Offending Risk Assessment Instruments

- None are normalized for females
- Juvenile Sex Offender Assessment Protocol (J-SOAP)
- Estimate of Risk of Adolescent Sex Offender Recidivism (ERASOR)
- Juvenile Risk Assessment Tool (J-RAT)

Physiological Assessment

- Visual Reaction Time

- Abel Assessment of Sexual Interest
- Subjective questionnaire + objective measure of subject's viewing of photographs of clothed male and female children, teens and adults

(Coric et al, 2005)

- Polygraph

- Multiple uses
 - Initial assessment
 - During treatment
 - Post treatment
- Purpose
 - Encourage honesty
 - Identify lack of honesty

(Coric et al, 2005; Lane, 1997)

(Coric et al, 2005; Lane, 1997)

(Lane, 1997; Rich, 2003)

(Lane, 1997)

- PVPG

Assessment of Disposition Options

- Capacity for risk management plan
 - Relapse prevention plan
 - Willingness to consider treatment
- Effectiveness of medications
- Access to likely victims
- Access to likely triggers
- Legal considerations
 - Registry issues

Treatment Components

Psychological

Biological

Treatment Goals

- Reduce the risk for future sexual misconduct/sexual offending behavior
- Improve quality of life of the adolescent
 - Decrease psychiatric symptoms (suffering)
 - Increase personal autonomy
 - Reintegrate into the community, where appropriate

Specific Goals

- Confront denial *
- Social skills
- ↓ Unhealthy sexual arousal (Ford, 2006)
- Clarify values
- ↑ Healthy sexual interests
- Clarify cognitive distortions
- Victim empathy
- Identify triggers and interventions

(Shaw et al, 1999)

How to Accomplish These Goals?

- Accurate diagnosis & differential diagnosis
- Use of evidence based treatments
 - Treatment of co-morbid psychiatric, neurological and/or medical disorders
- Ongoing violence risk assessment

Treatment Issues

(National Task Force on Juvenile Sexual Offending 1993)

- Acceptance of responsibility for behavior
- Identification of pattern or cycle of offense behavior
- Effective interventions to interrupt the sexual abuse cycle
- Victimization (e.g. sexual abuse) and issues for the offender
- Capacity for empathy with others, especially past victims

Treatment Issues

-continued

- Role of sexual arousal in offenses
- Sexual identity
- Consequences of offending
- Family issues that support offending behaviors
- Cognitive distortions related to offending behaviors
- Expression of feelings
- Skill deficits (social and academic)
- Substance use/abuse
- Relapse prevention
- Management of concurrent psychiatric disorders

Treatment Approaches

- Psychological - non-physically invasive
- Biological - chemical or physical intervention
- Combined

Psychological

- Behavioral
- Cognitive-Behavioral
- Psychoeducational
- Psychodynamic
- Multisystemic

Format

- Individual
- Group
- Family

Behavioral

- Focus on physiological events and stimuli and the resulting behaviors
- Exclusively behavioral techniques not typically used with juveniles
 - Aversive – questionable with juveniles
 - Olfactory
 - Faradic
 - Biofeedback

(Rich, 2003)

“Behavioral Mix”

Covert Sensitization

- Mental only
- Real stimuli

(Rich, 2003)

CBT

- Cognitive distortions
- Positive or negative consequences
- Behavioral > cognitive as age ↓
- Relearning and behavioral practice

(Rich, 2003)

Psychoeducational

- Social skills
- Coping skills
- Anger management
- Conflict resolution
- Stress management
- Relaxation
- ADLs
- Self-esteem

Psychodynamic

- Unconscious motivations and experiences affect emotions, thoughts, behaviors and relationships
- Identify and express the unconscious to increase insight and remove the power of the hidden issues
- Various approaches

(Rich, 2003)

MST

- Cognitive deficits
 - “Denial
 - Empathy
 - Distortions”
- Peer relationships
 - “Making ‘close friendships’”
- Family interactions
 - “Cohesion”
 - “Parental supervision”

(Bourke & Donohue, 1996)

Relapse Prevention

- Combination of CBT and psychoeducational techniques
- Identify the sexual offending cycle
- Identify personal triggers
- Develop alternatives to offending

(Rich, 1997)

Pharmacological

- Antiandrogens
- Antigonadatropics
- Hormonal
- SSRIs
- Antipsychotics
- Mood Stabilizers
- Anxiolytics
- Naltrexone

Rationale

- Treat comorbid psychiatric disorders
- Specific symptoms are not fully amenable to other treatment modalities (i.e., psychotherapeutic interventions)
- Cravings for sexual acts become/are intense and/or overpowering

SSRIs

General

- Easy dosing
- Familiarity with SSRIs
- Commonly used to treat other psychiatric disorders
- Benign side effect profile
- No special work-up needed

SSRI Use

- Efficacy difficult to determine
 - Heterogeneous samples
 - Small sample sizes
 - Varied outcome measures
- Recommend – use to target primarily compulsive sexual behaviors
- Do not use for “deviant sexual” behaviors
 - Sexual sadism
 - Pedophilia

(Saleh, 2004)

Pharmacological Management Questions

- What to use?
- When to use it?
- With whom should it be used?

Decision Considerations

- Client's age/physiological development
- Medical conditions
- Co-morbid psychiatric diagnoses
- Severity of sexually offending symptoms
- Parent/guardian input
- Response to non-pharmacological treatment

(Saleh & Grasswick, 2005)

Pharmacological Cautions

- Do not forget the co-morbidities
- “Off label use”
- SSRI
 - limited data
 - “black box warning” with adolescents

Settings

- Types
 - Community
 - Residential
 - Criminal Justice
- Decision makers
 - Court system
 - Mental health agency
 - Social services agency
 - Client's parent(s)/ guardian
- Considerations
 - Availability of treatment
 - Risk of re-offending during treatment
 - Availability of placement

Treatment Summary

- Effective treatment plan evolves from a comprehensive assessment of multiple influences affecting an adolescent's mental life
- Offense-specific treatment should be only part of a more comprehensive treatment program
- Some juvenile sex offenders are "at risk" of becoming adult offenders, but the majority do not follow this path
- Treatment prognosis is positive (Hunter et al, 2006)

Summary

- Public health issue
- Complex and heterogeneous population
- Identify your role and resources
- Systematic and thorough yet flexible in data gathering
- Seek consultation when appropriate

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