A Snapshot of Sex Offenders: Juveniles vs. Adults

National Legislative Briefing
Sex Offender Management Policy in the States

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Uniform Crime Report

• In 2005
  – 15.8% of all arrests for rape were of individuals under age 18
  – 20% of all arrests for other sex offenses were of individuals under age 18
  – 15.5% of all arrests (for any offense) were individuals under age 18
Uniform Crime Report

• In 2005
  – 98.6% of all arrests for rape were males
  – 91.7% of all arrests for other sex offenses were males

  – 76% of all arrests (for any offense) were males
Who are the sex offenders?

- There is no demographic profile
  - All races, religions, educational levels, professions
Who are the victims?

• Sex offenders in general:
  – have been known to target male and female victims, with females being at higher risk
  – are much more likely to target victims who are related or known to them (rather than strangers)

• Juveniles are even less likely to target strangers than adults
Range of Behaviors

- Behaviors on the part of juveniles and adults can range from hands off behaviors to hands on behaviors to penetrative behaviors
Some Differences

• Adults are more likely to be diagnosed with a paraphilia

• Paraphilias: mental disorders characterized by sexual fantasies, urges, or behaviors involving non-human objects, suffering or humiliation, children or other non-consenting person.
Some Differences

- Juveniles have fewer victims
- Juveniles are less compulsive
- Juveniles show more fluid patterns of arousal when assessed with psychophysiological measures
Classification by Types: Adults

- Child molesters: The MTC Classification System (Knight et al., 1989)
  - Degree of sexual preoccupation (high fixation, low fixation)
  - Degree of social competence (low competence, high competence)
  - Amount of contact with children
  - Meaning of the contact
  - Amount of injury
Classification by Types: Adults

• Rapists: MTC:R3 Classification (Knight & Prentky, 1990)
  – Primary motivation
    • Opportunistic
    • Pervasively angry
    • Sexual- sadistic
    • Sexual- non-sadistic
    • Vindictive
  – Social competence
Juvenile Sex Offender Typology

• Sample
  – N = 256 (5 states)
  – Ages 13-18, mean age = 16.2
  – Ethnicity:
    • 70% Caucasian
    • 21% African-American
    • 7% Hispanic
  – Community based or corrections operated
    (Hunter, Figueredo, Malamuth, Becker, & Conaway)
Juvenile Sex Offender Typology

• 3 prototypic subtypes
  – Life-course persistent
  – Adolescent onset, non-paraphilic
  – Early adolescent onset, paraphilic
Juvenile Sex Offender Typology

• Life-course Persistent
  – Greater exposure to male-modeled violent behavior
  – Substance abuse and pornography use prior to age 12
  – More self-reported non-sexual violent behavior during the 12 months preceding the study
  – Higher number of archival arrests for non-sexual crime
Juvenile Sex Offender Typology

• Early Adolescent Onset, Paraphilic
  – Highest number of prepubescent male victims (50%)

• Adolescent Onset, Non-paraphilic
  – Scored low on all classification criteria except psychosocial deficits
  – Less psychologically impaired and experimented with sexual offending and a delinquent lifestyle possibly in association with negative peers and developmental quests for autonomy
Assessing Adults

- Record review
- In-depth clinical, social, educational, and sexual histories
- Psychometrically sound psychological tests
- Physiological assessment techniques with good psychometric properties
  - A note about the polygraph
- Empirically derived risk assessment instruments
Risk Assessment Instruments

- HCR-20
- Mnsost-R
- RRASOR
- SORAG
- VRAG
- Static-99 – Revised Coding
- Static-2002
- Stable 2000
- SONAR

- In assessing risk, one should consider dynamic, static, and acute factors
Assessing Juveniles

- Assessment MUST be developmentally appropriate
- Particular attention should be paid to comorbid psychiatric problems (e.g., ADHD)
- Record review
- In-depth clinical, social, educational, and sexual histories
- Psychometrically sound psychological tests
  - Select tools validated for use with juveniles
  - Problems with self-report sex-offender specific assessments
Assessing Juveniles

• No currently validated physiological assessments for use with all juveniles
  – Research is ongoing to validate VRT measures (AASI, Affinity)

• There is no currently validated risk assessment instruments for juveniles
  – Juvenile Sex Offender Assessment Protocol-II
  – Estimate of Risk of Adolescent Sexual Offends Recidivism
2 major methods:

- Randomized controlled treatment studies
  - Random assignment to treatment and no treatment groups (SOTEP; Marques, et al., 2005)
- Matched comparison of treated and untreated samples
  - Meta-analysis of comparison studies (Hanson, et al., 2002)
### Treatment Outcome Research
(Marques, et al., 2005)

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Years at Risk (mean)</th>
<th>Sexual Reoffense</th>
<th>Violent Reoffense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relapse prevention (all)</td>
<td>259</td>
<td>8.3</td>
<td>22%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Volunteer control</td>
<td>225</td>
<td>8.4</td>
<td>20%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Nonvolunteer control</td>
<td>220</td>
<td>8.3</td>
<td>19.1%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>
## Treatment Outcome Research
*(Marques, et al., 2005)*

### Sexual recidivism by risk group

<table>
<thead>
<tr>
<th>Group</th>
<th>Low risk</th>
<th>Medium risk</th>
<th>High risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relapse Prevention</td>
<td>11.0%</td>
<td>21.6%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Volunteer control</td>
<td>11.1%</td>
<td>21.9%</td>
<td>43.3%</td>
</tr>
<tr>
<td>Nonvolunteer control</td>
<td>12.1%</td>
<td>14.6%</td>
<td>46.2%</td>
</tr>
</tbody>
</table>
Treatment Outcome Research (Marques, et al., 2005)

• Conclusions:
  – Too soon to say treatment works or doesn’t
  – Future research should:
    • Tailor treatment to offenders’ risk levels, treatment needs and responsivity
    • Monitor progress toward treatment goals
    • Utilize an aftercare component based on an individualized, interdisciplinary case management model
    • Include high-risk offenders
    • Conduct pre-treatment assessments on all participants
    • Have sufficient sample size to enable shorter follow-up period
    • Continue rigorous evaluation component
Effectiveness of Treatment for Sex Offenders
(Hanson, et al, 2002)

- Meta-analysis of 43 matched comparison studies
  - 9,454 subjects
    - 5,078 treated
    - 4,376 untreated
  - Included rapists and child molesters
  - 4-5 year follow-up period
  - Coded by type of treatment received
Effectiveness of Treatment for Sex Offenders (Hanson, et al, 2002)

- Offenders who received treatment were less likely to reoffend than those who did not
  - Sexual recidivism: 12.3% for treated and 16.8% for untreated
- But stronger effects were found for more recent treatments
  - Sexual recidivism
    - 17%: untreated
    - 10%: treated
  - General recidivism
    - 51%: untreated
    - 32%: treated
Effectiveness of Treatment for Sex Offenders (Hanson, et al, 2002)

- Best treatments
  - Adults – Cognitive-Behavioral

- Treatment programs delivered in the community were equally effective as those delivered in institutions

- Non-completers were at a higher risk to reoffend than treatment completers
Treatment of Juveniles: MST

• Borduin et al (1990): outcome for MST
  – MST vs. individual therapy
  – 12.5% vs. 75%
  – Follow-up on average 3 years
• Borduin & Schaffer (2002)
  – MST vs. Treatment as usual
  – Sexual recidivism 12.5% vs. 41.7%
  – Nonsexual recidivism 29.2% vs. 62.5%
Treatment of Juveniles

• Worling & Curwen (2000)
  – Nonrandomized treatment outcome study of CBT with juveniles
  – Significant effects on all types of recidivism
    • Sexual recidivism: 5% vs. 18%
    • Violent recidivism: 19% vs. 32%
    • Nonviolent recidivism: 21% vs. 50%
What we know about recidivism

• Hanson & Morton-Bourgon (2005)
  – Meta-analysis of 82 recidivism studies
  – 29,450 sex offenders
  – Deviant sexual preferences and antisocial orientation were the major predictors of sexual recidivism for both adult and adolescent sex offenders (very few adolescents were included in the sample)
What we know about recidivism

- Hanson & Morton-Bourgon (2005)
  - Average follow-up of 5-6 years
  - Sexual recidivism rate: 13.7%
  - Violent non-sexual recidivism rate: 14.3%
  - General (any) recidivism rate: 36.2%
What do we know about recidivism

• Juveniles, in general, reoffend sexually at a lower rate
  – One review of recidivism studies (Caldwell, 2002) found sexual recidivism rates ranging from 1.8% to 19.6%
Based on all of the above, we can make the following statements:

- Sexual recidivism rates for both adult and juvenile sex offenders are low.
- In general, juvenile sex offenders reoffend sexually at a lower rate than adult offenders.
- Juveniles and adults who do reoffend are more likely to reoffend nonsexually.
Common Misconceptions

- Juvenile sex offenders will become adult sex offenders
- Juveniles are in most ways similar to adult offenders
- Juvenile and adult offenders necessarily need long-term intensive therapy
- Juvenile and adult offenders require residential treatment in secure facilities
Recommended Approach

• Developmentally appropriate assessment methodology should be utilized in assessing individuals from any age category
• Treatment should not involve a one-size-fits-all approach but should be based on the particular needs, strengths, risks, and deficits of the individual
• Risk assessment instruments should be utilized in determining where treatment can occur and where offenders can be safely managed, maximizing community safety
Policy Issues

• In an effort to protect communities, legislators have enacted a variety of new policies, including:
  – Increased sentences
  – A return of civil commitment for sex offenders
  – Registration and community notification

• Have these policies made our communities safer?
  – There is a need for further empirical investigations into the intended and unintended effects of such legislation
Policy Issues

• What are the costs of these programs?
• Are there alternatives that may have a stronger impact on public safety?
  – Prevention
  – Management of offenders in community
Resources

• Association for the Treatment of Sexual Abusers
  – 4900 S.W. Griffith Drive, Suite 274
    Beaverton, Oregon U.S.A. 97005
    Phone: (503) 643-1023
    Fax: (503) 643-5084
    E-mail: atsa@atsa.com
    www.atsa.com

• Center for Sex Offender Management
  – www.csom.org

• Stop It Now!
  – http://www.stopitnow.com/
• Thank you for listening

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