Chapter 7

Summary and general discussion

Introduction

The nature of problems related to sexual offending has been suggested to differ from problems related to other criminal behavior (Hanson and Bussière 1998; Hanson et al 1995). In the meantime, relationships between sexual offending and individual characteristics of juvenile offenders have remained largely unexplored, especially when considering mental health characteristics. Therefore, the overall aim of this thesis was to investigate psychiatric disorders and psychosocial and offense related characteristics in subgroups of juvenile sex offenders and the predictive validity of these characteristics for persistent (sexual) offensive behavior. Various studies have demonstrated that subgroups of juvenile sex offenders differed in many respects (Hunter et al 2003; Worling and Långström 2003; Becker and Hunter 1997; Hsu and Starzynski 1990). Based on these recurring differences, a distinction was made between offenders abusing young children (child molesters), those abusing peers without co-offenders (solo peer offenders) and those abusing peers as part of a group of offenders (group offenders). Currently, it is unknown whether there is a relationship between mental health problems and risk for sexual reoffending. Therefore, the role of psychiatric disorders in recidivism was studied. Five studies were conducted and specific aims and results are summarized below. Followed by a general discussion.

Summary

To provide a best estimate of the prevalence of psychiatric disorders in adult and juvenile sex offenders, **chapter two** presents a review of the literature. Eight articles met inclusion criteria. Eighty percent of the sex offenders in the studied samples met criteria for at least one psychiatric disorder, but the range of prevalence rates per diagnosis was remarkably wide. Large methodological differences between the reviewed studies hamper interpretation of most results. In any event, the review demonstrated the scarcity of solid research on mental disorders in sex offenders and several issues and questions concerning this specific delinquent population and sex offender subgroups remain unresolved and unanswered.

The following chapters all concern a sample of male suspects of sex offenses aged 12-18 years referred to four (out of twenty-two) regional Child Protection Board offices and four (out of thirteen) juvenile justice institutions in the Netherlands. Although participants were legally considered to be only suspected of committing a sexual offense (i.e. arrested for/charged with a sexual offense), for the sake of readability they are called sex offenders or sexual delinquents.

In **chapter three** the prevalence of psychiatric disorders in (subgroups of) juvenile sex offenders and its relation with criminal recidivism was investigated in a sample of 106 adolescent sex offenders (mean age 15.0 $\pm$ 1.5 years). Psychiatric disorders were assessed by means of a semi structured interview (K-SADS-PL), the level of functioning by means of the Children's Global Assessment of Functioning Scale (CGAS) and recidivism was ascertained from registration systems. Three quarters of the study sample met criteria for at least one psychiatric disorder and comorbidity was found in more than half of the subjects. Moreover, functional impairment (CGAS below 61) was found in almost two thirds of the juvenile sex offenders. Rates were different between subgroups of sex offenders, child molesters showing higher rates of internalizing disorders and having a lower overall level of functioning as compared to solo peer offenders and group offenders. Moreover, child molesters had a history of being of sexually abused more frequently as compared to both other subgroups. Although none of the participants recidivated sexually, more than half of them re-offended non-sexually, and approximately one third committed violent offenses. Violent reoffending was predicted by the presence of any disorder, but not by any specific mental disorder. Compared to those who sexually offended only once, boys who had sexually offended more frequently showed higher rates of disruptive behavior disorder and anxiety disorder. Results of this study demonstrate the necessity of developing mental health services for at least certain juvenile sex offenders. The findings also support the relevance of differentiating juvenile sex offender subgroups. Screening and assessment of juvenile sex offenders is needed in order to provide mental health care to those identified with mental disorders. Although sexual recidivism was rare, it is necessary to respond to the fact that the majority re-offended non-sexually. Further investigation of (sexual) recidivism patterns (by means of self report questionnaires) in this sample is needed.

As it has been suggested that (sexual) offending and developmental disorders are possibly related (Van Wijk et al 2006), the objective of **chapter four** was to investigate autism spectrum disorder (ASD) symptoms in juvenile sex offenders by means of the Children's Social Behavior Questionnaire (CSBQ), a questionnaire to be filled in by parents. Juvenile sex offenders (n = 175, mean age 14.9 $\pm$ 1.4) were compared with respect to autistic symptoms with a matched normal control group (n = 500, mean age 14.0 $\pm$ 1.4 years) and a group of children with ASD (n = 114, mean age 14.2 $\pm$ 1.9). While levels of ASD symptoms were lower in juvenile sex offenders than in the ASD group, significantly higher levels were found in juvenile sex offenders than in normal controls. Furthermore, it was found that solo peer offenders and child molesters scored higher on several subscales as compared to group offenders. ASD core symptoms were most pronounced in child molesters as compared to other sex offender subgroups. This again indicates the need for differentiating subgroups of juvenile sex offenders. Foremost, our findings support the need for specific diagnostic assessment with respect to ASD symptoms in the juvenile sex offender population. Further study should investigate whether the higher levels of symptoms found in our study indicate that ASD occurs more frequently in the group of sex offenders.

A substantial proportion of adolescent sex offenses is committed in groups and while studies in adults have elicited substantial differences between group offenders and solo offenders, the study presented in **chapter five** aimed specifically to investigate the adolescent group sex offender subgroup. A sample of 89 group sex offenders (mean age 14.9 $\pm$ 1.4) was investigated. The main focus was on differences between leaders and followers with regard to psychiatric disorders, intelligence, and psychosocial and offense-related characteristics. Leaders and followers were similar in many respects. While leaders reported more emotional problems, followers were characterized by higher levels of problems in the social relational domain and by excessive use of force during the sexual act. Although some potentially relevant differences were found between leaders and followers, our findings did not support vast differences between the two groups, in contrast to what has been reported in the literature. Our inability to find differences may carry

methodological reasons, for example the method of classification (leader versus follower). Also, because offenders switch between the role of leader and follower roles may not be as clear as has often been suggested.

Chapter six reports on offense related characteristics and the psychosexual development of juvenile sex offenders as measured by the Global Assessment Instrument for Juvenile Sex Offenders (GAIJSO). This instrument is used in addition to the BARO, a global assessment tool for juvenile delinquents. The BARO is applied by the Child Protection Board to assess young offenders in order to advise the court whether or not extensive diagnostic assessment is indicated. The predictive validity of these characteristics for persistent (sexual) offensive behavior in subgroups of juvenile sex offenders (n = 174, mean age 14.9 $\pm$ 1.4) was investigated. Extensive diagnostic assessment was advised most frequently in the group of child molesters. In these youngsters there were indications of more internalizing and (psychosexual) developmental problems as compared to group sex offenders and solo peer offenders. Sexual recidivism was of low frequency and therefore it was impossible to investigate the predictive validity of offense related characteristics and psychosexual development. However, higher frequency of sex offending (i.e. being a multiple sex offender) was related to specific characteristics, like a problematic psychosexual development and the impulsive character of the offense. The information assessed by means of the GAIJSO points the way to further diagnostic assessment and treatment. It gives insight into the specific problems of juvenile sex offenders which remain underexposed after general assessment with the BARO or other instruments. Furthermore, it contributes to a well considered advice to the justice authorities and is important in initiating immediate and appropriate care.

Overall discussion

Over the past two decades, scientific research in the field of juvenile sex offending has revealed several important factors that are related to sexual offensive behavior in juveniles. Empirical data have confirmed the impressions of professionals in the field that family context, early sexual behavior and the experience of child sexual abuse

are important contributory factors in the development of abusive sexual behavior in juveniles (Barbaree and Langton 2006). Theoretical and empirical research on intimacy and attachment problems in adult sex offenders has broadened our understanding of the interactions between delinquent or criminal potential and sexuality (Smallbone 2006). Studies in the field have indicated that juvenile sex offenders constitute a heterogeneous group, but also that subgroups of juvenile sex offenders differ in socio-demographic, personality, psychiatric and developmental characteristics (van Wijk et al 2007a; Hunter et al 2000). Although individual characteristics are recognized to be of relevance for explaining the phenomenon of juvenile sex offending, previous research has neglected this issue, as was shown in the review in this thesis (chapter 2). While the focus of this thesis was primarily on individual characteristics within the mental health domain, it is recognized that risk factors for juvenile sex offending are multifactorial.

According to Grisso (2004), society should be concerned about adolescent offenders with mental disorders in order to meet its custodial treatment obligations. Public agencies have the legal and moral obligation to respond to the mental health needs of adolescents in their custody. The results presented in this thesis underline the need for involvement of child and adolescent psychiatric expertise in juvenile sex offenders. At least a subgroup of these youngsters has substantial mental health problems and are therefore entitled to receive proper treatment. Some conditions need further study, for example the higher level of ASD symptoms. If rates of autistic spectrum disorders are shown to be higher in juvenile sex offenders, this would argue for developing screening methods for this particular population.

Although the rates of psychiatric disorders found in the population under study call for the development of mental health services, it cannot be stated that improved care will affect the developmental course of these boys with respect to sexual (re)offending. Although a cross-sectional relationship was found between frequency of sex offending and specific child psychiatric conditions, the predictive validity of psychiatric disorders for sexual recidivism could not be established. As was found in other samples of juvenile sex offenders (Worling and Långström 2006;

Caldwell 2002), sexual recidivism was extremely rare, although the majority did re-offend non-sexually. This is an important finding in itself, as one may argue that it is inappropriate to consider these boys to be sex offenders. Labeling these youths as such may be counterproductive, as it can lead to an undesirable designation, with detrimental social consequences. Hence, it makes the necessity of specialized assessment and treatment of sexual offensive behavior disputable. Perhaps, we need to view these offenders as juveniles who committed a serious crime that in the majority of them may be a result of adverse development. Only registered sex offenses were investigated in this study. Offenses unknown to police, the so-called 'dark number', are unknown to us. It is possible that some boys stopped sexual offending once they had been detected by the authorities and that others continued their offensive behavior without getting caught. However, registration of non-sexual reoffenses for the majority of sex offenders could signify that the dark number explanation is more valid for sex offenses than for non-sex offenses. On the other hand, sexual offending occurs less frequently than non sexual offending, and only a small proportion of sexual offenses gets registered, which can also explain the lack of sexual reoffending in the current sample.

While juvenile sex offenders are comparable to general offenders in many respects, the current study does suggest some possibly relevant differences. The relatively low prevalence of CD and SUD reflects the observation that a subgroup of sex offenses is not committed in the context of a disruptive behavior pattern. However, the high prevalence of ADHD may suggest a relation with impulsivity. Juvenile sex offenders have also been described as socially isolated (Van Wijk et al 2006; Barbaree et al 1998; Hsu and Starzynski 1990; O'Brien and Bera 1986). In some, the sexual deviant behavior may therefore be driven by their inability to carry on normal sexual relationships. This may correspond to the relatively high prevalence of anxiety disorders and the rates of ASD symptoms found in our population. Yet, certain symptoms or disorders (such as depression and anxiety) found by our research aimed assessment could actually be a reaction to the sexual offense and its personal and legal consequences. Being labeled as a sex offender, especially as a child molester, causes serious emotional distress. Conditions such as depression

or anxiety may well be a congruent reaction to a shameful situation. Also the high rates of ADHD found in child molesters could be an expression of experienced trauma, rather than of longer existing ADHD (Vermeiren 2003). For this reason, it may be of relevance to conduct a follow-up study on this population.

Although the classification of sex offender subgroups was based on the empirically supported differences of solo versus group sex offenders and rapists versus child molesters, the validity of this classification is unknown. As only limited information on the sexual offense was available, and information from participants may well have been biased, the reliability of our findings cannot be ascertained. Despite these limitations, relevant differences were found between subgroups, many of which were expected considering previous studies in this field. Child molesters had the most mental health problems, followed by solo peer offenders. Although the group sex offenses in the study sample were of high severity, levels of psychopathology were remarkably low in group offenders. Underlying risk factors for sexual offensive behavior in these youngsters may better be sought in contributory factors like adverse environmental circumstances rather than in mental health problems.

As previous research suggested that sex offending might be associated with developmental disorders (Van Wijk et al 2007a), ASD symptoms were investigated in the current study. High rates of ASD symptoms were found and could be explained in two ways. First, there may be some selection bias. Presumably, because of lack of social understanding and misinterpretation of rules, juvenile sex offenders with ASD problems are more likely to get caught or referred than offenders without these symptoms; as a result they may be over-represented in studies like ours. Second, the instrument used was not intended to diagnose ASD and may not have been specific enough to accurately assess ASD because of some overlap with ADHD and ODD symptoms. However, despite these limitations, this thesis confirms previous studies in that there may be a relation between ASD and sexual offending (Hellemans et al 2007; Silva et al 2004). The finding that ASD symptoms were most pronounced in child molesters argues for further investigating the possible relationship between ASD and child molesting. Because of disturbances in social

interaction and communication child molesters can find it difficult to build normal (sexual) relationships with peers and they might therefore make advances towards younger children. Together with lack of empathy, the pursuit of obsessional interests, the misinterpretation of rules and the failure to recognize the implications of their behavior, lack of social understanding can possibly increase their susceptibility to child molestation. According to Anckarsäter (2008), subjects on the autism spectrum have special and a higher level of care needs than most people, and they are at increased risk of coming to harm in socially demanding and tough settings. This may well apply to juvenile sex offenders, especially child molesters, with high levels of ASD symptoms in juvenile justice settings. However, only scant research has been conducted on the relationship between sexual offending and ASD, warranting further study. This study suggests that psychiatric problems present in child molesters may have been underestimated in previous research, resulting in possible consequences for (early) intervention. Further longitudinal research is warranted to investigate the relation between these specific psychiatric problems of child molesters and outcome.

Limitations

The findings of this thesis must be assessed in the light of some limitations. Although juvenile sex offending has a relatively low prevalence, we were able to assess a unique and large sample of this particular group of offenders. However, in the present study, specific subgroups, such as child molesters, were small. The sample studied was a selection of juvenile sex offenders and no assertions can be made with respect to the external validity, i.e. the significance for other groups of sex offenders. In this particular sample, we do not know if the subjects answered truthfully; social desirability is presumably present in this group of offenders. Although not necessarily a limitation, participants were legally considered to be only suspected of committing a sexual offense (i.e. arrested for/charged with a sexual offense). Results would probably have been different if, for example, only convicted sex offenders were included. With respect to ASD symptoms only self-report questionnaires were used and no diagnostic assessment was performed. Therefore clinical ASD diagnoses could not be made. Because the assessment of

ASD is complex and time-consuming it was not possible to organize clinically based categorical diagnostic assessment in a large scale epidemiological study like the one presented here. General psychiatric assessment by means of the K-SADS-PL was for the same reasons only performed in a subsample.

Clinical implications

The numerous psychiatric problems and disorders found in juvenile sex offenders demand proper and sufficient screening and assessment. This screening should be comprehensive and should preferably take place shortly after referral to the police. Specific diagnostic assessment with respect to ASD symptoms seems desirable; however, further study should investigate whether ASD indeed occurs more frequently in the group of sex offenders.

This study shows that besides environmental factors, as demonstrated in previous research, individual characteristics are important contributory factors in the development of sexual delinquency in juveniles. Results presented in this thesis underline the need for involvement of child and adolescent psychiatric expertise in juvenile sex offenders. In order to meet its custodial treatment obligation society needs to respond to the mental health needs of juvenile sex offenders in custody. Although treatment is necessary for those with mental disorders, we do not know in what way treatment will shape the future of juvenile sex offenders and if it will prevent future (sexual) offending. The low frequency of sexual recidivism is an important clinical finding and suggests that caution is warranted when labeling these offenders.