HIV/AIDS: Implications for Juvenile Sexual Offenders and their Victims

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Abstract

The purpose of this paper is to explore the implications of the Human Immunodeficiency Virus (HIV) for juvenile sexual offenders and their victims. Following a discussion of the epidemiology of HIV among adolescents and youth in the United States, the risk factors associated with the transmission of sexually transmitted infections (STIs), including HIV, among juvenile sexual offenders will be outlined. The legal and ethical issues associated with juvenile sexual offenders known or suspected to be HIV positive will be explored, and intervention strategies for helping to prevent the spread of HIV among this population will be discussed.

Key Words: HIV, AIDS, juveniles, offenders, sex, sexual crimes
HIV/AIDS: Implications for Juvenile Sexual Offenders and their Victims

HIV presents a serious health issue for youth, in general, and poses a particular problem for juvenile sexual offenders and their victims. Because of the risk factors associated with transmission, juvenile sexual offenders are likely to be at increased risk for HIV infection. The victims of juvenile sexual offenders with HIV also are at risk for acquiring the disease, further compounding the negative outcomes resulting from sexual crimes committed by juveniles.

**Epidemiology**

*General Population Estimates of HIV*

HIV has been established as an epidemic in the United States and abroad (Centers for Disease Control, 2003). It is estimated that at least 1.3 million people in the United States are living with HIV and that approximately 40,000 new infections occur each year. Many people with HIV go untested, untreated, or both and while the number of AIDS cases has stabilized due to medical advances, more opportunities for transmission exist as a larger number of people are living with HIV.

Epidemiological trends suggest that youth are among the fastest growing groups affected by this disease. Epidemiological data also reveals health disparities with the greatest incidence of HIV and AIDS among minorities and the economically disadvantaged. In fact, young female minorities represent one of the fastest growing groups infected with HIV. A large percentage of minority groups live at or below poverty level with little or no access to medical care, condoms, or health education (Gary et al., 2000). Furthermore, lower socio-economic status is correlated with higher rates of intravenous drug use, which contributes to direct infection through the shared use of injection paraphernalia. There also is a correlation between noninjection drug use and HIV/STI infection given that risky sexual behavior increases when inhibitions are lowered.
(Devieux et al., 2002; Knox & Chenneville, 2006). Rates of HIV among minority populations are further exacerbated by the lack of culturally appropriate sexuality education.

*Estimated Rates of HIV among Juvenile Offenders*

The prevalence of HIV and other sexually transmitted infections (STIs) is disproportionately high among correctional institution populations, including juvenile correctional facilities, worldwide (Seal, 2005). In some countries, 20% to 40% of the correctional populations are infected with HIV or other STIs. It is estimated that the AIDS prevalence in prison populations within the United States is roughly five times that of the general population (Braithwaite, Hammett, & Jacob Arriola, 2002). This is due, in part, to the fact that minorities are over represented in correctional facilities. Given that this population is at increased risk for HIV and other STIs, as previously discussed, there is likely to be higher rates of STIs in correctional facilities given the high concentration of minorities. Indeed, African American incarcerated youth are considered to be at even greater risk for HIV infection (Gary et al., 2000). The fact that condom distribution is limited and/or discouraged at many correctional facilities despite high rates of sexual activity among inmates (Robertson, Stein, & Baird-Thomas, 2006; Robertson & Levin, 1999) further compounds issues related to the incidence of HIV among incarcerated individuals. While the prevalence of HIV and STIs among juvenile delinquents is documented, there is a paucity of data regarding the prevalence among juvenile sexual offenders specifically (Teplin, Mericle, McClelland, & Abram, 2004; Canterbury, Clavet, McGarvey, & Koopman, 1998). However, given that juvenile sexual offenders, by definition, engage in high risk behavior, the rates of STIs among this population likely are high (Donenberg et al., 2001; Seal 2005).

Risk Factors associated with HIV among Juvenile Sexual Offenders
Risk factors for HIV among juvenile delinquents include drug and alcohol use, intravenous drug use, mental illness and infectious disease co-morbidity, such as Hepatitis (Devieux et al, 2002). Note that certain strands of Hepatitis, such as Hepatitis C, typically are contracted through the same behaviors by which HIV is transmitted (Malow et al., 2006). Robertson & Levin (1999) found that most juvenile offenders report being sexually active, having an early onset of sexual activity, and participating in unsafe sexual practices. A relationship between adolescent psychopathology and HIV risk behaviors also has been documented (Donenberg et al., 2001). Specifically, delinquency has been linked to drug and alcohol use, a known risk for HIV infection, and aggression has been linked to risky sexual behavior. Sexually violent offenders may be at increased risk for HIV due to the relationship between aggression and risky sexual behavior. While risk factors for HIV within general juvenile offender populations have been studied extensively (Teplin, Mericle, McClelland, & Abram, 2003; Godin et al., 2003), the examination of risk factors associated with HIV among juvenile sexual offenders is a relatively new area of study (Chang et al., 2003).

Knowledge and attitudes about HIV also may represent risk factors for juvenile sexual offenders. While there is a lot of data available about AIDS knowledge and sexual risk-taking behavior among juvenile offenders in general, there is relatively little data available that specifically addresses juvenile sexual offenders (Chang et al., 2003; Godin et al., 2003). In one study, researchers compared juvenile sexual offenders to a group of runaways (Rotheram-Borus, Becker, Koopman, & Kaplan, 1991). Results indicated juvenile sexual offenders were less knowledgeable about HIV and less likely to engage in safe sex practices. Trisdale (1999), in a more comprehensive study, examined male juvenile sexual offenders exclusively. Variables included ethnicity, sexual orientation, total lifetime number of sexual partners, HIV and AIDS
knowledge, personal views about sex, and depression ratings. Results from this study revealed that, in general, male juvenile sexual offenders had limited knowledge about HIV and possessed a low intent to engage in safer sexual behavior in the future. In addition, there was a negative correlation between HIV knowledge, intent to engage in safer sex, and depression ratings. As depression scores increased, HIV knowledge and intent to engage in safe sex decreased.

Mandatory HIV Testing

When considering the implications of HIV and other STIs among juvenile sexual offenders, several legal and ethical questions arise. Most of these questions surround the issue of mandatory testing and treatment. Clearly, mandatory HIV testing for juvenile sexual offenders represents a controversial issue and will be the primary focus of this section. Consider the following:

A 17-year old male is convicted of raping a 12-year old girl. He has a documented history of substance abuse and aggressive behavior, known risk factors for HIV transmission. He refuses to submit to an HIV test. Should HIV testing be required against his will? What if the 17-year old male has been arrested and is awaiting trial, but has not yet been convicted?

Arguments in favor of mandatory testing rest on the ideas that testing (a) may reduce the further spread of HIV by alerting the offender and, possibly, the victim to an HIV diagnosis, (b) will allow for treatment of HIV for the victim and the offender, and (c) may reduce anxiety among the victims of sexual crimes. Arguments against mandatory testing are bolstered by the protection against unreasonable search and seizure afforded by the Constitution’s Fourth Amendment. Opponents also stress that testing the victim is the only way to ensure his/her
protection. Given the window period between HIV infection and the development of antibodies, which can be detected by most HIV tests, false negative test results are possible. Therefore, the only way to ensure an accurate test result is for the victim to be tested on multiple occasions. With valid arguments for each position, this issue becomes a political, legal and ethical quagmire.

The courts have ruled on this issue, and the opinions rendered reveal a trend in favor of mandatory testing. For example, the Supreme Court of Washington ruled that a state statute requiring HIV testing carried benefits to society that outweighed juveniles’ privacy interests (Matter of Juveniles A, B, C, D, E, 1993). The ruling cited consistency with public health policies, which aim to reduce the incidence of STIs in society. In addition, the ruling emphasized the potential benefits to the juveniles being tested, specifically with regard to the provision of medical treatment.

In a California case, a minor child named Benjamin committed a lewd and lascivious act against another minor child. Benjamin was placed on probation, fined $100 and was adjudicated as a ward of the court. After being placed in a group home, Benjamin came before the same court on similar charges. The Court terminated probation, committed Benjamin to the California Youth Authority, imposed another $100 fine, and ordered Benjamin to submit to an HIV test. Benjamin appealed the test, claiming that penetration had not taken place. The court ruled that according to California law, every person convicted of a sexual offense, regardless of penetration, must submit to a blood test for HIV (In re Benjamin G., 2004).

In Arizona, a state law forcing juvenile sex offenders to submit to an HIV antibody test was found not to violate the Fourth Amendment’s protection against unreasonable search and seizure (In and for County of Maricopa, 1995/1996). However, in this state, neither judges nor
prosecutors can order the tests. Rather, the victim, or his/her parents or guardians, must request the test. Note this applies only to adjudicated delinquents who either committed a sexual offense or significantly exposed a victim to the offender’s blood or bodily fluids not to include saliva, tears, or perspiration (Matter of Appeal in Maricopa County Juvenile Action No. JV-511237, 1995/1996).

In New Jersey, a trial court refused to order HIV tests for three juveniles accused of raping a minor. The Court relied upon medical testimony that suggested the best way for the victim to learn of his/her status was to undergo HIV testing (State in Interest of J.G., 1997). However, the trial judge’s decision was reversed on appeal, based on the finding that mandatory HIV testing may help to alleviate the victim’s anxiety about HIV status (Supreme Court of New Jersey, State of New Jersey in the Interest of J.G., 1997).

A few states have enacted statutes that address both sides of the issue, attempting to protect the rights and future well-being of both juvenile sexual offenders and their victims. For example, the Florida HIV Testing Act (2005) focuses on the victim’s right to know whether his/her alleged offender is infected with HIV. The victim’s parents or guardian must request the testing, and the results cannot be used in court to convict or impugn the defendant. In addition, the opportunity for HIV pre- and post-test counseling is mandated, allowing the alleged offender an opportunity for education and/or intervention. Similarly, a 2006 Alaska Statute allows for HIV testing for alleged offenders, at the request of the victim or their parent/guardian(s). This statute does not address HIV counseling, treatment, or education for the offender or the victim(s).
Intervention Strategies

Righthand & Welch (2001) argue that sex education must be included as a content area for any sexual offender treatment program to be effective. This argument is supported by others as well. Becker & Kaplan (1993), who developed a cognitive behavioral treatment program for sexual offenders, ranked sex education at the top of mandatory content areas for sexual offender treatment programs. Other areas included cognitive restructuring, empathy training, values clarification, impulsivity control training, social skills training, reduction of deviant arousal and relapse prevention. Despite the importance of comprehensive sexuality education for juvenile sexual offenders, a review of the literature reveals only a small number of sex education programs specifically designed for juvenile sexual offenders (Schlapman & Cass, 2000). However, there are many sex education programs designed for the general juvenile offender population, and these will be examined in the paragraphs to follow.

St. Lawrence et al. (1999) compared sexual risk reduction skills training (ST) to anger management (AM) interventions among 428 incarcerated male juveniles. Random assignment was used in this study with juveniles assigned to either the ST or AM intervention. Compared to juveniles in the AM group, juveniles in the ST group reported greater AIDS knowledge, self-efficacy, positive attitudes about condoms, and condom use. Juveniles in the AM group showed no attitudinal changes following the intervention although both groups displayed a significant decrease in risky sexual behavior and drug use at a six-month follow up. This finding was attributed to informal “peer teaching”.

Another study, perhaps the most comprehensive to date, examined the efficacy of an HIV and STD intervention program designed for adolescents with social adaptation difficulties in juvenile rehabilitation centers (Godin et al., 2003). The intervention was grounded in the theories
of reasoned action, planned behavior, interpersonal behavior and social cognitive theory. The intervention consisted of 10 sessions ranging from 75 to 90 minutes in length with topics to include the following: the meaning of sexual intercourse; unsafe and safer sexual activities; the pros and cons of condom use; values and sexuality; negotiation of safer sex; communication skills; self-affirmation; and arguing to overcome obstacles to safer sexual behavior. Experiential learning activities were used in tandem with these topics. Activities included group discussions, role-playing, brainstorming, problem solving, demonstrating condom manipulation, improvisation and audiovisual document presentations.

Results revealed significant improvement for juveniles in the experimental group in the following areas: intent to use condoms, self-efficacy, personal/normative beliefs and attitudes toward condom use, behavioral beliefs, perceptions of behavioral control and knowledge about HIV/STIs. The fact that self-report questionnaires were used, and that many of the questions were open-ended, were limitations in this study.

When tailoring an HIV prevention program for juvenile sexual offenders, several obstacles can be foreseen. These obstacles surround the inherent difficulty in defining the attitudes, beliefs, and behaviors of the typical juvenile sexual offender. For example, is it possible to define the “typical” juvenile sexual offender? How do the perceptions of sexual intercourse differ for juvenile sexual offenders, and how do these perceptions affect behavior? How does the typical juvenile sexual offender differentiate between unsafe and safe sexual activities? In judging the benefits and drawbacks to condom use, will the typical juvenile sexual offender see any benefit to condom use other than personal protection and, if so, will this serve as motivation to behavior change? Communication skills and negotiation for safer sex become
meaningless, at best, for a person whose pattern of actions does not take into account the wants and needs of their victims.

Research findings to date reveal the chasm between what is known and what is unknown in the area of STI, including HIV, prevention among juvenile sexual offenders. Interventions specifically designed for this population are needed, which will require more information about the function and typology of sexual behavior among juvenile sexual offenders. Furthermore, information about HIV knowledge, behavioral skill level, and behavioral intentions among juvenile sexual offenders is needed.

**Conclusion and Future Directions**

A review of the literature in the area of HIV among juvenile sexual offenders reveals the dearth of information available at present. Society’s general attitude toward sexual offenders combined with negative stereotypes associated with HIV attribute to a pattern of inaction that only exacerbates confusion in this area. Research that is available tends to focus on juvenile offenders generally and not juvenile sexual offenders. There are vast differences between these two populations yet many programs designed for juvenile offenders are used for juvenile sexual offenders. Research is greatly needed to include epidemiological research on the rates of HIV among juvenile sexual offenders and effective intervention strategies. Further, the legal and ethical issues surrounding mandatory testing require more attention.
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