Understanding the Adolescent Sex Offender:
Risk Factors, Assessment Tools and Treatment

A Review of the Literature

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Abstract

Adolescent sex offenders pose a significant problem for society. A number of empirical studies have identified risk factor characteristics correlated to sexual abuse recidivism rates. Risk factors and assessment tools are identified and discussed in terms of treatment approaches and clinical implications.
Introduction

Research on adolescent sex-offenders suggests that a minimum of half a million juveniles perpetrate a sex crime every year. (Valliant, Bergeron 1997 as cited in Kelly, Lewis, and Sigal, 2004). 20% of rapes, 25% of sexual abuse cases, and 30% to 50% of child sex abuse cases are perpetrated by juveniles. In 1994, the Federal Bureau of Investigation found that a minimum of 15% of all reported sex crimes in the United States were perpetrated by adolescents. (Miner, 2002). Adolescent sexual offending is a significant problem. Often these crimes go unreported or under-reported due to the inherent secrecy and shame that often go with sexual abuse. (Witt, Bosley, Hiscox 2003).

Research suggests that nearly one in three adolescent sex offenders go on to commit more serious sexual assaults in adulthood (Longo and Groth, 1983, as cited in Moody, Brissie, Kim, 1994). A sample of one-hundred thirty-seven convicted adult sex offenders admitted that their first offense took place in adolescence (Groth, Long, McFadin, 1982, as cited in Moody, Brissie, Kim, 1994).

Clinicians who work with this population must be able to identify inherent risk factors in order to identify and separate those adolescents who pose the most direct threat to the larger community. A plethora of research currently exists examining common characteristics that place an adolescent at higher risk to re-offend sexually. The issue of sexual perpetration by juveniles has received increased attention over the past decade due to several factors. An increased awareness of the prevalence of sexual offending behaviors and a increased sensitivity to the harm caused to victims are just two of the reasons. (Prentky, Harris, Frizell, and Righthand, 2000, as cited in Christodoulides, Richardson, Grahm, Kennedy, and Kelly 2005). Adolescent sex-offenders are also an important population to follow due to the evidence showing that a large
proportion of adult sex-offenders committed their first sexual offenses in adolescence. (Christodoulides, Richardson, Grahm, Kennedy, and Kelly 2005).

The literature concurs that there are clear benefits to distinguishing high-risk versus low risk adolescent sexual offenders. Answering the questions of which placement and treatment intervention would best serve the offender, the victim and the community as a whole are best addressed with tools of risk assessment. (Christodoulides, Richardson, Grahm, Kennedy, and Kelly 2005). Studies show that low-risk cases tend to have higher levels of treatment effects while higher risk adolescents do not appear to respond as well to treatment. Noteworthy, however, is that even high risk adolescents have been shown to reduce the level of recidivism with treatment. Any improved recidivism rates are important in reducing harm to victims and the financial impact on society (Kelly, Lewis, and Sigal, 2004).

Risk assessment of an adolescent sexual offender typically begins at the time of arrest and is generally assessed again at the time of release or completion of a sex-specific treatment program. The purpose is to answer the question as to whether or not a particular youth will likely commit another sex-crime. In order for a clinician to accurately assess and predict the chances for recidivism, he or she must have an awareness of the current knowledge in the field. The purpose of this paper is to review the literature on common characteristics and risk factors in adolescent sex-offenders in order to gain a better understanding of the developmental pathways inherent in this group and how to best serve them.

Research indicates numerous possible causalities for the perpetration of sex offences in juveniles. Risk factors are generally divided into two sub-groupings. Static risk factors are described as being unchangeable while dynamic risk factors describe areas which have the potential for change. Numerous tools to measure and rate these variables exist and are used by
clinicians to ultimately ascribe a risk level to individual offenders. To date, no assessment measure can invariably predict whether or not an individual will definitely re-offend. Clinicians are being called on more to concentrate on the potential for change in individual clients rather than focusing on the question of whether or not an individual will re-offend. (Christodoulides, Richardson, Grahm, Kennedy, and Kelly 2005).

Originally, treatment of juvenile sex-offenders was based on studies of adult offenders. Based on his own research in the area, Michael Miner asked the question of whether or not recidivism risk factors differed substantially between adult vs. adolescent offenders. He eventually concluded that the factors related to in the transition from adolescence into adulthood criminality are inherently different from those factors that tend to support ongoing adult criminal behavior. (Miner, 2002). Therefore, although there may be similarities in patterns of behaviors, risk assessment in juvenile sex-offenders must use appropriate evidence based tools.

The risk factors and characteristics described in the following paragraphs do not include every possible factor mentioned in the literature. It is intended to be a general overview of seemingly important areas of concern in regards to sex crime recidivism rates. For the purposes of this paper, only studies of adolescent male sex offenders were reviewed. This is not to say that sexual crimes are never perpetrated by females. Far less research exists involving female subjects and the risk factors may not be the same.

Risk Factors

Upon entering treatment, adolescent sex-offenders present with multiple demographic characteristics which are called risk factors. Any of the risk factors can interfere with treatment. Adolescent sex offenders display a variety of common characteristics that place them at higher risk for perpetrating sexual crimes than peers who do not commit sex related crimes. It should
be noted that there is no absolute recipe for the creation of an adolescent sex-offender per se. The research does, however, show some level of correlation between certain characteristics and potential for sexual acting out.

Studies support a multi-factorial explanation for the etiology of adolescent sexual abuse behaviors. They can be explained in environmental, familial, interpersonal and developmental elements (Manocha and Mezey, 1998). Adolescent sexual abusers tend to come from chaotic and abusive family situations. They have often experienced disruption in care (Fehrenbach et al., 1986 as cited in Manocha and Mezey, 1998). Studies show a tendency to be isolated from their peers (Awad et al., 1984; Saunders et al., 1986 as cited in Manocha and Mezey, 1998). They also experience a wide range of psychological problems. Conduct Disorder, learning disabilities and problems of low self-esteem are common features. Academic difficulties and other non-sexual antisocial behaviors are often seen in these individuals as well. Adolescent sex offenders can be found in all race and socioeconomic classes. No one group is over represented (Fehrenbach et al., 1986 as cited in Manocha and Mezey, 1998). Impulsivity is associated with increased risk for re-offense (Miner, 2002). Having been sexually and or physically abused has been correlated to sex offense recidivism (Miner, 2002). The use of verbal threats during the commission of a sex offense, victim blaming and denial or minimization of the offense are also related to recidivism rates (Miner, 2002). Preoccupation with children was found to be a predictive factor in recidivist rates, while length of time spent in treatment was associated with decreased recidivism (Miner, 2002).

Some research shows that 70% to 80% of adolescent sex offenders have been sexually abused in childhood (Groth and Freeman-Longo, 1979 as cited in Moody, Brissie, Kim, 1994).
Additionally, a large portion of this population tends to have sexual experiences in elementary school.

Involvement with delinquent peers is consistently referred to in the literature as a common risk factor variable related to recidivism (Christodoulides et al., 2005). A prior sex offense conviction, child victim choice, cognitive distortions and a history of truancy are all noted as risk factors related to sexual offense recidivism (Langstrom, 2002). Characterization of adolescent sex offenders includes a described lack of intimacy, distorted reality and strong feelings of powerlessness (Bowen, 1978; Imber-Black, 1993, 1998; Selvini, 1997 as cited in Galcer, Tornusciolo and Eisenstadt, 2003). Langstrom and Grann found that young offender age was correlated to recidivism risk (2000).

Langstrom and Grann (2000) outlined a variety of variables that showed evidence of some level of correlation to recidivism. They included historical factors such as adverse family climate, low levels of school performance, signs of early onset conduct disorder, previous sex offense behavior, prior violent conviction and three or more prior violent convictions of any type of crime. Clinical factors included poor social skills, intellectual impairment, low levels of empathy, psychopathy, substance abuse problems, not working or studying and denial of offense. Offense related factors included non contact offense, any victim under twelve years of age, any male victim, stranger victim, use of threats or weapons, physical injury to victim, offending on two or more occasions and having offended two or more victims.

The following paragraphs will expand on some of the important factors reviewed to date. It is not an exhaustive list, but rather an overview of commonly cited correlations with sexual abuse recidivism rates.

*Family Background*
Studies have shown that adolescent sex offenders have many of the same risk factors as their criminal acting out counterparts. A lack of protective parenting is described as being a characteristic of many young sex offenders (Manocha and Mezy, 1998). Problematic family environment including sexual abuse, physical abuse and neglect are all too common in the histories of a majority of adolescents who end up in the criminal justice system. Research shows that adolescent sex offenders as a group have a markedly higher incidence of exposure to familial violence characterized by more frequent occurrence of both physical and sexual abuse (Van Ness, 1984; Davis and Leitenberg, 1987; Lewis et al., 1979, 1981; Rubenstein et al., 1993; Ford and Linney, 1995 as cited in Duane, Carr, Cherry, McGrath and O’Shea, 2002).

The family environment in which an adolescent sex offender grows up in is said to shape their personalities and development over time (Baker, Tabacoff, Tornusciolo and Eisenstadt, 2003). Current knowledge of the family dynamics of juvenile sex offenders is lacking. To address this issue, Baker, Tabacoff, Tornusciolo and Eisenstadt compared a group of juvenile sex offenders to a matched group of juvenile offenders who had not committed a sex crime. They hypothesized that juvenile sex offenders are more likely to come from families that involve high levels of deception and secrecy as compared to their criminal counterparts. They suggested that families of sexual offenders are rife with secrecy. They compared a group of twenty-nine adjudicated juvenile sex offenders to a group of thirty-two youth diagnosed with conduct disorders. The findings showed that the group of sex offenders were more likely to have family myths (20.7% vs. 3.1%), exhibit taboo behaviors (24.1% vs. 0%), and have been told lies by their families (37.9% vs. 6.3%). Family myths were defined as being a fiction or half truth about a family member that is more or less believed. Taboo family behavior was described as Satanism, sexual activity among family members or sex with animals. They suggested that a
resulting lack of intimacy, a distorted reality and feelings of powerlessness are potential negative consequences for children who grow up in deceptive families.

In regards to family functioning, Duane, Carr, Cherry, McGrath and O’Shea discovered that the high-risk juvenile sex offenders who did not respond to treatment had decidedly lower levels of parental care and poorer levels of family functioning than peers who did respond to treatment intervention (2003). In a study comparing parenting profiles of sex-offender parents vs. parents of adolescents receiving mental health care vs. parents of healthy adolescents receiving no services, some interesting results were found. They discovered that the parents of the juvenile sex offenders had a significantly more extensive history of having experienced child abuse themselves. The study also suggested that parents of the juvenile sex offenders witnessed more drug and alcohol abuse in their own youth than parents of the control groups had. The other significant finding was that the adolescent sex offenders had a significantly higher number of out of home placements due to behavioral issues than their counterparts.

Having a family environment that tends to be marked by physical abuse, sexual abuse and neglect can be detrimental to a child. Chemical abuse issues within the family and a pervasive tendency towards deception can all be contributing factors in creating a risk factor of potential sexual abuse. Other family factors suggested in the literature are a history of incarcerations by the parent, as well as parental psychiatric illness (Kelly, Lewis, Sigal, 2004). Having parents who abuse substances and criminal behavior by the father have consistently been correlated with both non-sexually adjudicated youth and juvenile sex offenders. When a psychiatric illness of the parent is added to criminal history and chemical abuse issues, ability to form healthy attachments and demonstrate good parenting skills is likely to be limited (Kelly, Lewis, Segal, 2004).
Lower Social Competence

Social skills deficits are thought to be a predictive factor in placing an individual at risk for a sexual re-offense (Miner, 2002). These deficits include factors such as poor knowledge in regards to sex, high levels of denial and little awareness as to the exploitative nature of the offending behavior. Social competence has been described by Miner as the ability for an individual to both develop and maintain interpersonal relationships (2002). The quality of peer relations is considered to be an important factor when assessing social competence. Dating relationships and ability to achieve emotional intimacy with a sexual partner can be measured under this category as well.

It is thought that many adolescents who sexually offend tend to have poor levels of social skills, which leaves them feeling isolated from their peers and incapable of forming meaningful relationships, including sexual relationships. These adolescents, due to their social skills deficits, end up spending more time with younger children with whom they feel more comfortable and at ease. For potential child molesters and those at high risk for re-offense, this lack of social skills may manifest itself as a preoccupation with children. Preoccupation with children significantly increases the risk of sexual recidivism (Miner, 2002).

Low levels of social competence in adolescent sex offenders make it difficult to form healthy, age-appropriate, intimate relationships with others. They may ultimately sexually offend due to severe interpersonal and cognitive deficits (Witt, Bosley and Hiscox, 2003).

Antisocial Associates/Role Models

Delinquency is one of the most significant predictors of sexual offense recidivism. In a study by Ageton (1983), delinquency of adolescent sex offenders was measured across four variables. Only one variable, involvement with delinquent peers, correctly classified the vast majority of
adolescents (Christoulides et al., 2005). It has long been evidenced that youth exposed to antisocial peers and adults are more at risk for criminal behaviors including the perpetration of sexual crimes. Antisocial persons have a tendency to exploit others and to use coercive tactics to gain their particular goals (Hunter, 2004).

In an important study by Hunter, childhood exposure to violence against women and male-modeled antisocial behavior were shown to be significant risk factors for sexual aggression (2004). He described a subtype of antisocial men as it relates to masculinity. Hostile masculinity is described as reflecting both distrust and hostility toward women. Hostile masculinity is said to be a result of anticipated rejection and a subsequent need to dominate women in interpersonal relationships. Males in this category tend to endorse stereotypical rape myths. They are also able to justify and legitimize violence. Hunter goes on to say that the risk for sexual aggression is increased in adolescents who are exposed to antisocial males displaying Hostile Masculinity (2004).

It would make sense that the attitudes, ideas and actions of all youth are modeled after others. If an adolescent sex offender is continually exposed to antisocial peers and role models who endorse exploitative behaviors he will be at higher risk to offend both criminally and sexually.

Paraphilias/Victim Selection

The presence of one or more paraphilias places an adolescent at higher risk to sexually re-offend. Presence of paraphilia can also be related to victim selection as in Pedophilia. It has been found that child victim choice places a juvenile sex offender at higher risk for sexual recidivism (Langstrom, 2002). Deviant sexual arousal patterns are associated with general criminal, violent and sexual recidivism in juvenile sex offender populations (Gretton, in press as cited in Langstrom, 2002).
Male victim choice is also often cited as a risk factor for future sexual offending. Some studies, however, have not duplicated this finding for juvenile sex offenders in particular. Langstrom asserts that male victim choice as well as multiple victims is correlated with higher rates of sexual recidivism in youths. Other factors involved in victim selection can place an individual in a higher risk category for the possibility of re-offense. Any stranger victim, more than one victim and child victims are all considered to be risk factors for future criminal sexual conduct (Langstrom, 2002).

Literature on adult sex offenders shows a high level of correlation between deviant sexual arousal and sex offense recidivism (Rice, Quinsy, and Harris, 1991 as cited in Christoulides et al., 2005). In a sample of seventy male juvenile sex offenders, Kenny, Keogh and Seidler (2001) found a direct correlation between deviant sexual fantasies and sexual offense recidivism (Christoulides, et al., 2005). Another study by Langstrom and Grann concurs. Kahn and Chambers, however, did not find a strong correlation between deviant arousal in their sample of juvenile sex offenders and rates of recidivism.

It has long been thought that sexual victimization is a risk factor for sexual offense recidivism. Evidence in the literature for this claim is somewhat weak. Rasmussen, (1999) Knight and Prentky (1993) found only a weak correlation between juvenile sex offenders who had been sexually abused and eventual recidivism (Christoulides, et al., 2005).

*Educational Problems*

Difficulties in school including truancy and suspensions have been correlated with general and sexual criminality in youth. Presence of a Conduct Disorder often occurs in tandem with educational/behavioral problems in youth. These issues often overlap with problems in the family and associations with antisocial peers. It is important, however, to address the issue
separately, in regards to risk assessment. Langstrom found a direct correlation between truancy and all forms of recidivism in adolescents (2002).

**Substance Use/Dependence**

Substance abuse is correlated with a high proportion of sexual violence; date and acquaintance rape, rape of strangers, violence among intimate partners and child molestation. Research shows a direct connection between substance abuse and sexual abuse. Juvenile and adult sex offenders use substances for reasons of decreasing inhibitions, excusing sexually acting out behaviors, avoiding accountability, manipulating potential victims and exploiting vulnerable victims.

Many juvenile sex offenders have grown up in families marked with drugs, alcohol and criminality. A culture of substance abuse becomes a normalized way of life for these adolescents. Studies show that up to 50% of juvenile sex offenders report having used alcohol at the time of their offense (Kelly, Lewis, Segal, 2004). It has been speculated that one possible reason for the correlation between alcohol use and subsequent sexual offending behavior is the abuser’s desire to reduce inhibitions, making it easier to commit the sexual acts.

Alcohol and other controlled substances do not cause and individual to commit a sex crime. Juvenile sex offenders are, however, often described as having coexistent chemical abuse problems (Lightfoot and Barbarce, 1993 as cited in Kelly, Lewis and Segal, 2004). Substance abuse is commonly accepted as being a significant risk factor in sexual offense recidivism.

**Recidivism Rates**

Society has reason to be concerned about recidivism rates for adolescent sex offenders. Protection of the community must be first and foremost. Most studies have confirmed that sexual recidivism rates for adolescent sex offenders are low.
Sipe, Jensen and Everett (1998) studied a sample of 124 juveniles who had “non-violent” sex offenses against persons under 16. They found that 9.7% of their sample went on to commit a sexual offense as an adult. In a control group of non-sexual adolescent offenders, 3% of the sample committed a sexual offense as an adult. The average follow-up period for this study was six years.

In another study 197 adolescent sex offenders were followed after completing a sex specific treatment program. (Schram, Milloy, and Rowe 1991). The follow-up period was anywhere from two to seven years. 12% of their sample went on to be arrested for a new sexual offense. 37% had no new arrests. 63% had new arrests with the majority of those being non-violent felonies or misdemeanors. 15% of their sample was later arrested for non-sexual violent offenses. This study asserts the two years following discharge from a treatment institution represented the period of highest risk. (Schram, Milloy, and Rowe 1991).

Another study followed 96 adolescent sex offenders from Minnesota. All of the offenders had participated in a correctional adolescent sex offender program. (Miner, Siekart and Ackland 1997). The average follow-up period was less than 2 years. This study found that 8.3% of the sample was arrested for a new sexual offense. 10.4% were arrested for a crime against a person during the follow-up period while 27.2% of the sample was arrested for a crime that did not involve another person.

In a study by Rasmussen (1999) similar recidivism rates were found. In a sample of 92 adolescent sex offenders 54% committed a new non-sexual offense. 14% of the sample committed a new sexual offense. The follow-up period for this particular study averaged five years which is thought to reflect the slightly higher re-offense rates.
Wienrott (1996) completed an extensive review of the studies involving recidivism rates for adolescent sexual offenders. He asserted that contrary to popular opinion, virtually all studies confirm that relatively few adolescent sex offenders are ever charged with a new sex crime. Wienrott contended the reasons for the low number of subsequent sex crimes were difficult to ascertain. Some possible reasons suggested included lack of opportunity, increased surveillance, deterrence, humiliation, inadequate research methods, or clinical treatment.

**Risk Assessment Tools**

While recidivism rates for adolescent sex offenders to commit a new sexual offense appear to be fairly low it is imperative that clinicians have tools for prediction of who is “at risk” to re-offend. Schram, Milloy, and Rowe (1991) determined that treatment staff was able to accurately identify those clients who were at “low risk” to sexually re-offend. Interestingly, only 18% of adolescent sex offenders that treatment staff identified as “high risk” actually re-offended sexually. Rowe (1991) pointed out the tendency treatment providers have to over predict future sexual offense rather than fail to predict recidivism that may ultimately occur. The result is that offenders may be kept in treatment and institutions longer than necessary. Accurate empirically validated tools to predict rates of sexual offense recidivism are a necessity for clinicians working with this population.

Worling (2004) points out the need for accurate risk assessment tools. “Estimates of the risk for future sexual offending assist with decisions regarding many critical issues such as the level of community access, the timing of family reunification, and the delivery of specific treatment interventions.” There is a difference between clinical judgment and actuarial instruments. Actuarial assessments are based on an objective scoring system for a fixed set of risk factors while clinical judgment is subjective. Actuarial assessment is considered superior to clinical
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judgment in the field (Barbaree, Seto, Langton, and Peacock 2001). Additionally, actuarial instruments tend to use identified risk factors based on research of large samples of individuals.

The ERASOR

The Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) is one tool which clinicians can use in estimating short term risk of sexual offense for adolescent sex offenders. The most current version of the ERASOR includes a checklist of twenty-five risk factors which are divided into five categories (Worling, 2004). The twenty-five risk factors are divided into five distinct categories: 1) Sexual Interests, Attitudes and Behaviors, 2) Historical Sexual Assaults, 3) Psychosocial Functioning, 4) Family/Environmental Functioning, and 5) Treatment. Additionally, the tool offers a category for provision of “Other Factor” where case specific risk may be included by the clinician. Worling notes the nine Historical Sexual Assaults items are static or unchanging while the remaining sixteen items are dynamic with potential to change. The tool is intended to be used by clinicians every six months to measure change. Clinicians code the instruments by determining whether each risk factor is considered present, possibly or partially present, not present, or unknown (Worling, 2004).

Under the category of Sexual Interests, Attitudes and Behaviors, the clinician is required to check as present, possibly or partially present, not present, or unknown the following static characteristics: 1) Deviant sexual interest (younger children, violence or both), 2) Obsessive sexual interests/pre-occupation with sexual thoughts, 3) Attitudes supportive of sexual offending, and 4) Unwillingness to alter deviant sexual interests/attitudes.

The category of Historical Sexual Assaults is considered static. The risk factors clinicians consider here are: 1) Ever sexually assaulted two or more victims, 2) Ever sexually assaulted same victim two or more times, 3) Prior adult sanctions for sexual assault(s), 4) Threats of, or
use of violence/weapons during sexual offense, 5) Ever sexually assaulted a child, 6) Ever sexually assaulted a stranger, 7) Indiscriminate choice of victims, 8) Ever sexually assaulted a male victim (male offenders only), 9) Diverse sexual assault behaviors.

The category titled Psychosocial Functioning contains the following characteristic checklist: 1) Anti-social interpersonal orientation, 2) Lack of intimate peer relationships/social isolation, 3) Negative peer associations and influences, 4) Interpersonal aggression, 5) Recent escalation in anger or negative affect, 6) Poor self-regulation of affect and behavior (Impulsivity).

The Family/Environmental Functioning category requires the clinician to determine the level or lack of presence of the following four characteristics: 1) High –stress family environment, 2) Problematic parent-offender relationships/parental rejection, 3) Parent(s) not supporting sexual-offense specific assessment/treatment, 4) Environment supporting opportunities to re-offend sexually.

The next category identified in the ERASOR, includes those factors associated with treatment. The two identified factors are 1) No development or practice of realistic prevention plans/strategies, and 2) Incomplete sexual-offense specific treatment. Again, the clinician is asked to determine whether each factor is considered to be present, partially/possibly present, not present, or unknown.

The final category is labeled as “Other”. Here the clinician has an option of including case-specific risk factors deemed important. One example may be the refusal of an adolescent to cease his offending behaviors (Worling, 2004).

Subsequent to completion of the checklist, a clinician is asked to rate individual adolescents as to their level of current risk. Worling attempted to validate his instrument in a study of interrater agreement. In this study, risk ratings were compared from twenty-eight clinicians who
evaluated one-hundred and thirty-six adolescent male sex offenders after comprehensive, clinical assessments and interviews (Worling, 2004). He points out that clinical judgment is central to determining risk level even when using empirically guided tools such as the ERASOR. Interrater agreement was calculated for each of the twenty-five risk factors, not just the total score for over-all risk rating. Worling found the average rating of individual factors was at or above .60 for all but one factor. He found the average rating for overall clinical risk estimate (low, moderate, or high) to be .92. The results suggested acceptable levels of inter-rater agreement concerning overall risk level estimate (Worling, 2004).

Worling, J.R., and Curwen, T. (2001) point out the necessity of re-evaluating risk estimates every six months to one year. They cite reasons of rapid development changes during the period of adolescence, as well as the potential for change in many of the factors. Additionally, it is noted that a youth should be re-evaluated after significant “social, environmental, familial, sexual, affective, physical, or psychological change” (Worling, J.R. and Curwen, T., 2001). It should also be considered imperative to re-evaluate subsequent to new disclosures based on youth self report.

J-SOAP-II

Another instrument with data supporting its use with adolescents is the Juveniles Sex Offender Assessment Protocol-II (J-SOAP-II) (Fanniff and Becker, 2005). The tool was initially developed in 1994 by Prentky and Righthand. In order to improve inter-rater reliability, some wording was changed resulting in the J-SOAP-II (Prentky and Righthand, 2003.) Studies suggest the J-SOAP-II is a reliable instrument capable of detecting differences within populations of juvenile sex offenders (Prentky and Righthand, 2003; Prentky, Harris, Frizzell and Righthand, 2000; Righthand et al, 2005; Fanniff and Becker, 2006). It is important to note
the instrument is not predictive of sexual offense. It is a tool/checklist which is meant only to
guide clinicians in the treatment and risk management of individual adolescents (Prentky and
Righthand, 2003).

The JSOAP-II is divided into four distinct scales or categories. Each scale has a number of
items reflecting the larger category. Clinicians are asked to score each item giving a numerical
value of zero to two (Prentky and Righthand, 2003). Thirty-two items are considered static.
Twenty-four items are dynamic.

Scale One is the “Sexual Drive/Pre-Occupation Scale”. The eight items included on the scale
are: 1) Prior legally charged sex offenses, 2) Number of sexual abuse victims, 3) Male child
victim, 4) Duration of sex offense history, 5) Degree of planning in sexual offense(s), 6)
Sexualized aggression, 7) Sexual drive and pre-occupation, and 8) Sexual victimization history
(Prentky and Righthand, 2003).

Scale Two is the “Impulsive Anti-social Behavior Scale”. The authors identified eight items
falling under this category. The items are: 1) Caregiver consistency, 2) Pervasive anger, 3)
School behavior problems, 4) History of conduct disorder, 5) Juvenile anti-social behavior, 6)
ever charged/arrested before age sixteen, 7) Multiple types of offenses, 8) Physical assault
history and/or exposure to family violence (Prentky and Righthand, 2003).

Scale Three is the “Intervention Scale”. The seven identified items clinicians are asked to
score are: 1) Accepting responsibility for offense(s), 2) Internal motivation for change, 3)
Understands risk factors, 4) Empathy, 5) Remorse and guilt, 6) Cognitive distortions, and 7)
Quality of peer relationships (Prentky and Righthand, 2003).

The fourth and final scale is the “Community Stability/Adjustment Scale”. Five items are
scored on this scale. The items include: 1) Management of sexual urges and desire, 2)
Management of anger, 3) Stability of current living situation, 4) Stability in school and 5) Evidence of support systems.

As with the ERASOR, a clinician ultimately assigns a risk level of high, moderate, or low to the adolescent being assessed. Although there is a growing body of research to support its validity, the J-SOAP II’s predictive value has not yet been established (Fanniff and Becker, 2006).

Methodology

No research study is without flaws. The literature reviewed is no exception. Commonly noted discrepancies include; problems with self-report, researcher bias and recidivism rates based on actual records.

When studies are based on self report alone, the validity of variables could be compromised by the response set (Duane, Carr, Cherry, McGrath and O’Shea, 2002). Researcher bias must always be considered in examination of findings. Studies looking only at actual re-arrest rates for sexual offense recidivism will no doubt not be reflective of actual re-offense numbers as some crimes go unreported.

Some of the studies cite a small sample size making direct comparison to other studies difficult. Mean age of offender and whether the sample was taken from a residential versus outpatient setting can affect outcomes.

Inclusion of all types of sex offenses can skew results as well. Rapists, child molesters, exhibitionists and incest offenders all present with some differing typology. Should there be a higher proportion of a certain type of sex offender, outcomes may be affected.

The Duane study points out that their sample was one of convenience and not a random sampling. Their control groups were small which limits the power of statistical tests in the
detection of inter-group differences (Duane, Carr, Cherry, McGrath, O’Shea, 2003). Finally, the majority of dependent variables were based on self-report. This particular study goes so far as to say that the results can not be generalized to the entire population of adolescent sexual offenders. They could be generalized to adolescents who are in outpatient sex offender treatment settings in Ireland.

The studies reviewed did not all measure the same variables and therefore describe different risk factors involved in sexual offense recidivism. They can not be compared side to side. A thorough review of empirical studies does reveal many themes pointing towards multiple factors involved in the etiology and developmental pathways of the adolescent sex offender.

Caution must always be urged when interpreting results of any study and the literature reviewed on risk factors associated with juvenile sex offenders is no exception. Langstrom (2002) points out that there is notable overlap in risk factor variables indicative of both violent criminal and sexual re-offense behaviors. The lay person may see little need for separating the different types of recidivist activities. The results, however, should be meaningful to clinicians responsible for planning and delivering appropriate interventions for young people who sexually offend.

Clinical Implications

There are a number of clinical concerns in regards to addressing risk factors for adolescent sex offenders in correctional and treatment environments. Some studies have found that not all adolescent sex offenders respond to treatment (O’Reilly, et al., 1998 as cited in Kelly, Lewis and Sigal, 2004). It is suggested that low risk sex offenders respond better in most cases. In a meta-analysis examining recidivism subsequent to treatment, 19% of adolescent sex offenders committed another sexual offense (Hall, 1995 as cited in Kelly, Lewis and Sigal, 2004). The
base rate for recidivism for untreated sexual offenders is between 15% and 35%. Therefore, any reduction in recidivism is desirable for society as a whole.

Clinicians must be able to assess an offender’s level of risk in order to make several important decisions affecting numerous people. Determining risk aids in the decision of where to appropriately place a perpetrator, whether residential or out-patient treatment is necessary and how to minimize future risk of re-offense. Making more effective dispositions which are consistent with the offenders’ level of dangerousness and intervention needs is the way to help correctional and rehabilitative approaches have success with adolescent sexual offenders (Smith, Wampler, Jones and Reifman, 2005). They go on to point out that entry of a low risk adolescent into the justice system can traumatize the family by labeling their child as a sex offender and, ultimately, by placing the low risk adolescent on a sex offense registry for years to come. Exposing a low risk adolescent to criminally orientated peers can be detrimental as well.

Keeping adolescents who commit sex crimes out of the system has even worse potential by allowing violent and dangerous recidivists to remain in the community without supervision or treatment (Smith, Wampler, Jones and Reifman, 2005). Determination of level of treatment intervention is one of the most serious clinical considerations for adolescent sex offenders. A number of self report instruments exist and are commonly available to professionals in the field. Currently, however, there is no empirically validated method to classify adolescent sex offenders from least to most restrictive treatment settings (Smith, Wampler, Jones and Reifman, 2005).

In treating adolescent sex offenders, program developers would be wise to consider the developmental issues and needs which are unique to adolescents. Although the statistics around prevalence of adolescent sex offending behaviors are alarming, sexual recidivism rates for this population are typically low (Weinrott, 1996 as cited in Smith, Wampler, Jones and Reifman,
This finding suggests that there is a significant subgroup of adolescent sex offenders who do not go on to commit sex crimes in adulthood. Avoiding labeling and placing an emphasis on separating the offense from the individual is called for to avoid self-fulfilling prophecies.

Treatment effectiveness is concerned with holding the adolescent accountable for his current sexual behavior problems while recognizing the difference between the behavior and the individual (Smith, Wampler, Jones and Reifman, 2005).

The only known way to reduce the risk of sexual re-offense is to reduce an individual’s current risk factors. As noted previously, risk factors can be described as static or dynamic. Static risk factors are historical, permanent and cannot be altered. They include things such as; number of prior convictions, use of a weapon, having been a victim of sexual abuse. A perpetrator’s history cannot be changed. Therefore, the only factors that can be addressed clinically are those that are dynamic and changeable.

**Family Background**

An adolescent’s family atmosphere is of great concern when addressing risk. Growing up in a family with chemical abuse, domestic abuse, inappropriate sexual boundaries and parental psychiatric illness all put an adolescent at higher risk for re-offense. The degree of family secrecy has been shown to be a predictive factor for sexual offense behaviors. Growing up with an anti-social father who is violent towards women has also been correlated with sexual offending. Any number of other family concerns could be added to this list. Treatment providers cognizant of risk reduction must make family therapy for juvenile sex offenders a primary focus of concern. Although historical factors within the family cannot be changed, intensive family therapy can help alter distorted family dynamics. Clinical intervention targeting family secrets and resultant shame must be a primary focus of treatment. Witt, Bosley and
Hiscox point out that the treatment programs most effective for adolescent sex offenders place heavy emphasis on family involvement (2003).

Social Competence

Another primary concern for treatment intervention is raising the level of social competence for individual offenders. Social skills can be taught. A variety of treatment techniques can be used in addressing this issue. Cognitive behavioral therapy focusing on alternatives to aggression is standard in most treatment settings for adolescent sex offenders. Learning self-control and conflict resolution are goals as well as developing positive, pro-social relationships with adults and peers (Witt, Bosley and Hiscox, 2003).

Anti-social Associates

The reduction in number of antisocial associates has been shown to reduce the risk for sexual offense recidivism. Adolescents who surround themselves with other juvenile delinquents are at risk for committing all variety of crimes. Any good therapeutic program must first do no harm. Therefore it would seem imperative to not place lower risk offenders with those at higher risk. By doing so, the adolescents in a lower risk category become surrounded with more antisocial associates than they might have been before exposing them to a more criminal mentality and the normalization of inappropriate behaviors. Good tools of risk assessment can aid in the appropriate placement of adolescents so that an individual’s risk factors are not increased due to an inappropriate intervention.

Paraphilia/Victim Choice

Clinical intervention must also include focus on possible paraphilia and victim choice. Psychotropic medication can aid some offenders in areas of obsession and compulsion. Deviant sexual fantasies and the reinforcement of them through masturbation can be reduced with
appropriate treatment techniques. Relapse prevention plans can aid the adolescent in understanding and avoiding future situations that may place him at risk of sexual re-offense behaviors. The fact of prior victim choice and existence of paraphilia will remain present as risk factors. However, with proper intervention the risk can be reduced in this area.

*Education*

Prior history of disruptive school behaviors, suspension and truancy will also remain a static risk factor. Current and future school attendance and cooperation can and must be an area of concern when attempting to lower an adolescent sex offender’s risk for recidivism. Having the opportunity to have some level of success in a school setting is an important adjunct to self-esteem and future contribution to community. Treatment facilities working with adolescent sex offenders must cooperate effectively with the school as part of a comprehensive risk reduction measure.

*Substance Abuse*

Of dire clinical concern for numerous adolescent sex offenders is a co-occurring disorder related to substance abuse. When the two occur in tandem, they must be treated simultaneously as well. It goes without saying that an adolescent who abused chemicals prior to, during or after the commission of a sexual offense will be placing himself at risk to re-offend if substances continue to be used. Addressing these issues clinically will be paramount for risk reduction.

*Treatment Approaches*

Treatment of adolescent sex offenders generally includes a combination of group, family, and individual therapy. As each adolescent is unique, therapy should be tailored to presenting concerns. Once an adolescent has been assessed, a determination is made as to the level of intervention necessary. Those individual who are at higher risk of re-offense may receive in-
patient treatment while others may be treated in a community based setting. Proper assessment is critical so that scarce resources are used effectively. Additionally, a low risk offender receiving inpatient treatment may ultimately be harmed by his exposure to higher risk peers.

James Worling points out that traditional sex-specific treatment is aimed at the reduction of deviant sexual fantasies, attitudes and behaviors. Good treatment, however, cannot be aimed solely on the removal of problem behaviors. It must include the support of positive alternatives. Adolescents need to learn tools which will support them in all areas of their lives (Worling, 2004). A review of effective treatment programs for antisocial youth revealed that positive outcome is related to behavior programs which include individual, family and group therapy and focus on the teaching of new pro-social skills in a concrete manner (Lipsey, 1995).

The Center for Sex Offender Management (CSOM) has identified a variety of necessary components in an effective treatment program (CSOM.org, 1999). These components include: gaining control of problematic behaviors and teaching impulse control, teaching assertiveness skills and conflict resolution to help manage anger, teaching social skills to increase self-confidence and social competency, enhancing offender empathy for their victim, relapse prevention skills, increasing self-esteem and cultural pride, value clarification and sexual education (CSOM.org, 1999).

**Social Skills**

While not all adolescent sex offenders have deficits in social skills, many do. Socially competent individuals are able to interpret both verbal and non-verbal cues. They are active listeners. They are able to regulate their own affect and encourage reciprocity in relationships (O’Reilly and Worling, 2004).
There appears to be a direct correlation between poor social skills and an adolescent’s self-esteem, academic success and relationships with both peers and family members. The purpose of teaching social skills to the adolescent sex offender is to provide them with the tools to form healthy future relationships (O’Reilly, and Worling, 2004).

Common interventions in the enhancement of social skills with youth include the use of role-play, modeling, group discussion and feedback and homework assignments (Goldstein and McGinnis, 1997). In their manual Skill-Streaming, Goldstein and McGinnis outline several necessary social skills under the category labeled “alternatives to aggression”. Some of the skills in this category include “avoiding trouble with others”, “keeping out of fights”, and “using self-control”. Other adolescents who do not display more overt anti-social behaviors would benefit from focusing on skills in the category labeled “joining in”. These skills include “expressing your feelings” and “standing up for your rights” (Goldstein and McGinnis, 1997).

Other adolescents may need very basic social skills training in areas such as “listening”, “starting a conversation”, “introducing yourself”, and “asking a question”. Adolescents who have basic skills but tend to be lacking in empathy may benefit from skills such as “sharing something”, “understanding the feelings of others”, and “being a good sport” (Goldstein and McGinnis, 1997).

**Anger Management**

It is widely assumed that much of sexual offending behavior is tied to the under-controlled expression of anger (O’Reily and Worling, 2004). The feeling of anger is an often cited emotion experienced by adolescents immediately prior to their sexual offending behavior (Steen and Monett, 1989; Way and Balthazar, 1990). Adolescent sex offenders may display their anger in different ways. Some may be overtly aggressive. These youth tend to assume others are angry
with them and they focus on more hostile environmental cues (Dodge et al, 1990). Other adolescents avoid anger cues in the environment and prevent themselves from outwardly expressing their anger (Spielberger, 1999). These youth tend to be withdrawn, passive, depressed and unassertive (Spielberger, 1999).

Good treatment programs aim to teach adolescents how to identify both internal and external triggers which cause them to feel angry. Development and practice of alternative coping skills are necessary components. The use of role play, modeling, group discussion, feedback and homework, are particularly useful interventions.

A study by Howell et al (1997) discovered that negative affect can also be an immediate precursor to criminal behavior in adolescents. The authors found commonly identified negative affect to include; depression, parental rejection, peer rejection, hopelessness and a sense of isolation by the adolescents self-report (Howell et al, 1997). Therefore, targeting the treatment of depression in some adolescents’ may be as critical as anger management skills.

**Sex Education**

Limited sexual knowledge does not lead to adolescent sex offending behaviors. Many adolescents who do not commit sexual crimes have limited sexual knowledge (O’Reily and Worling, 2004). Some adolescents develop distorted sexual attitudes and beliefs as a result of their offending behavior or their own prior sexual victimization.

Sex education for adolescent sex offenders must not be limited to teaching simply physiology. Clinicians must assist adolescents in the development of healthy attitudes toward dating and intimate relationships. In the O’Reily test (2004), Worling identifies various skills to be addressed. Basic dating skills include topics such as how to make a date, choose an activity and coping with rejection. Additionally, ideas such as sexual values, the consent process and the
relationship between sex, love and intimacy should be addressed (O’Reily and Worling 2004). Other issues to be addressed may include sexual harassment, possessiveness and jealousy. Topics such as objectification and sexual identity are also important.

One good intervention tool is the use of video. This can be a powerful way to create a venue for discussion of topics related to human sexuality and values. Use of role play, modeling, group participation and feedback, as well as homework are good interventions in the teaching of sexual education and intimacy. Furthermore, wise clinicians are careful to be inclusive in their discussions of intimate relationships and sexuality. Adolescents who are struggling with issues of sexual identity must be considered and not alienated in discussions. For example, a role play acting out how a person might ask for a date should include both opposite sex and same sex dialogue possibilities.

Prior Victimization

Watkins and Bentovim (1992) point out that adolescent sex offenders are at least four times more likely to have been sexually abused than their peers who have not offended sexually. Between forty and 55 percent of adolescent sex offenders disclose being sexually abused themselves (Watkins and Bentovim, 1992). Across studies, nineteen to fifty-five percent of adolescent sex offenders have sexual abuse histories. Post treatment data typically finds higher rates of reported abuse (52%) versus pre-treatment data (22%). The reason for this discrepancy is most likely the idea that an adolescent is more likely to disclose his own abuse history after forming a trusting therapeutic relationship (Worling, 1995).

Each individual is different and not all adolescents are impacted by their own victimization in the same way. That said, in a study by Veneziano et al (2000), it was discovered that adolescent sex offenders with sexual victimization histories were more likely to repeat behaviors they
experienced as a victim. In the study, offenders who experienced anal penetration as a victim were fifteen times more likely to offend their victim in the same fashion (Veneziano et al, 2000). Adolescents who were sexually abused by males as a child may struggle with sexual orientation issues especially if they became aroused during the abuse (Watkins and Bentovim, 1992). Other adolescents have been abused by parents or siblings. Still others have suffered long term sexual abuse which may have paired fear or violence with arousal (O’Reily and Worling, 2004).

Identified common symptoms in adolescents who have been sexually victimized include: depression, anxiety, impulsivity, social withdrawal, antisocial activities, increased anger and self-harming behaviors (Kendall-Tackett et al, 1993). Sexually specific symptoms may include intrusive memories and flash backs as well as becoming upset at the mention of sexual topics (O’Reily and Worling, 2004).

Some clinicians believe an adolescent sex offender must first deal with his offending behavior prior to discussing his own abuse. Others contend an offender who has been a victim of sexual abuse must first resolve their own victimization. Worling (2005) argues the issues must be dealt with concurrently. Adlerian clinicians are cognizant of the idea that it is not what an individual may have experienced, but what he or she makes of that experience that matters. A holistic approach would be in agreement with Worling in dealing concurrently with the adolescent’s offending behaviors and victimization history.

Empirical support is considerable for a cognitive-behavioral approach to treatment for adolescents who have been sexually abused and suffer symptoms of post-traumatic stress (Saywitz et al, 2000). Deblinger and Heflin (1996) base an approach to treatment of sexual abuse victimization on three components.
Coping skills training include practicing of intervention techniques to cope with affective distress. Adolescents learn to identify and express feelings, practice relaxation techniques and to replace of distorted abuse related thoughts.

Gradual exposure is the next phase outlined by Deblinger and Heflin (1996). Adolescents are asked to discuss sexual issues which create low anxiety initially. As they are able to deal with the anxiety, they are progressively asked to discuss more anxiety provoking topics. The goal is for the individual to think and speak about their own victimization without intense anxiety, traumatic, flashbacks, disassociation, or other problematic thoughts or behaviors (Deblinger and Heflin, 1996).

The final approach according to Deblinger and Heflin (1996) is to provide the adolescent who has been sexually abused with sexual education. Learning about healthy sexuality, intimacy and boundaries is crucial for both victims of sexual abuse as well as the offender.

*Impulse Control*

Evidence suggests that heightened impulsivity is predictive of sexual recidivism (Loeber, 1990; Worling, 2001). There is also evidence that heightened impulsivity is correlated with increased risk of other criminal behavior (Lipsey and Derzon, 1998; Loeber, 1990; Worling, 2001). Kendall and Braswell (1993) argue that impulsivity is related to numerous other problems for adolescents. Impulsivity can be a factor in learning difficulties, peer rejection, aggression, risk-taking behaviors and problematic relationships with parents (Kendall and Braswell, 1993).

A focus on teaching impulsive adolescents problem solving techniques is imperative. Kendall and Braswell outline a five step problem solving technique that can be taught easily to adolescents.
The first step is to define the problem. Adolescent’s ask themselves, “What am I supposed to do?” Next, the problem is approached. The adolescent asks and answers the question, “What are all the possibilities to solve this?” The focus of attention is achieved by the self-statement “I need to concentrate on only this problem now”. The adolescent chooses an answer. “I think this is the one”. Finally, the follow-up statement is made: “I did a great job”, or “I’ll concentrate harder next time and maybe I’ll get it right” (Kendall and Braswell, 1993). Adolescents are taught to verbalize the five steps until they become automatic.

Modeling and role play are effective techniques for teaching problem solving to impulsive adolescents. Worling (2004) points out the necessity of the therapist to model not only proper task execution, but also how to cope with error and failure (O’Reily and Worling, 2004).

*Family Involvement*

Involving the parents of adolescent sex offenders is a critical, empirically supported component of treatment (Worling, 2004). Parents of these adolescents often must deal with issues of shame and denial of their child’s behavior. Anger towards their adolescent may be prevalent. Anger focused on the victim may also be present. Some parents may blame themselves or their child’s perpetrator. Some parents may have been victimized themselves and their unresolved issues may become a focus of attention. Other parents may blame the ‘system’ and have difficulty accepting their child’s behavior as inappropriate.

Treatment programs that involve families are considered to be more effective than those that do not. Additionally, familial support is thought to be a factor in reduced recidivism (Rasmussen, 1999). Parents of adolescent sex offenders have several strategies that have been found to be useful. (Gray and Pithers, 1993).
Parents reported that written information regarding the consequences of sexual abuse relapse prevention and cognitive distortions was helpful. Educational videos on the importance of accountability were appreciated. The opportunity to be included in therapy sessions was cited as helpful. Being involved in a support group for parents of sexually abusive adolescents was important. Finally parents found it useful to include the concerns of siblings in the treatment process (Gray and Pithers, 1993).

If parents are expected to be supportive of their adolescent in the treatment process, it stands to reason their inclusion is imperative. Of course each family circumstance is unique and there may be occasion when parental inclusion is counter-indicated. For example, a parent who has had their rights terminated due to severe physical or sexual abuse may be counter-productive to an adolescents’ treatment. As with any individual, family treatment must be tailored to meet the needs of each family.

Future Research

Understanding, addressing and reducing factors that place an adolescent sex offender at risk for future sexual offending behaviors is of great importance to society. Continued research on this population of perpetrators will be of utmost importance. To date, insufficient attention has been paid to the role of family functioning in the etiology and treatment of adolescent sex offenders (Baker, Tabacoff, Tornusciolo and Eisenstadt, 2003). Future studies focused on this factor would be of aid for clinicians who treat adolescent sex offenders and their families.

Research is indicative of girls being most commonly chosen victims of sexual assault. Adolescent sex offenders have been shown to have a disproportionally high incidence of sexual victimization in childhood. The question of why some victims of sexual abuse become perpetrators while others do not has not been answered. Future studies might attempt to uncover
why there are more female victims of sexual abuse, but fewer female perpetrators (Moody, Brissie, Kim, 1994). Other studies might focus on male victims of sexual abuse to examine differential factors as to why some male victims eventually perpetrate sex crimes while others do not.

Studies focusing on community reintegration of adolescent sex offenders are necessary. Where an individual is eventually placed upon completion of treatment may have implications in regards to risk of sexual re-offense. The literature reviewed did not address this concern.

Additional research on treatment outcomes measuring what techniques or modalities work and what ones don’t in regards to risk reduction would also be beneficial. Currently, there exists no assessment tool in determining who will vs. who will not re-offend. Reducing an offender’s level of risk is the best any clinician or treatment program can hope for. This goal is not unobtainable. Having a clear understanding of the multiplicity of risk factors for sexual offending behaviors in adolescents is the first step in reducing potential harm to victims.

Conclusion

Empirical studies examining risk factors in adolescent sex offenders will continue to expand knowledge in the field and aid clinicians who treat this population. Adolescent sex offenders pose a serious concern to society. They present with multiple risk factors.

Chaotic family background characterized by a lack of protective parenting, abuse, neglect, psychiatric illness and substance abuse, as well as familial violence and out of home placement of the youth in question are all too common.

Adolescent sex offenders tend to be lacking in appropriate social skills. This can serve to isolate the youth making it difficult to form appropriate peer aged relationships. A resultant lack
of self-esteem is presumed. Adolescents with low levels of social competence may end up being
drawn to younger children who are their developmental equals.

There is a strong correlation between antisocial associates and sex offending behaviors.
Involvement with other delinquent peers and male modeled antisocial behaviors have been
shown to have a direct link to criminal sexual acting out. Feelings of entitlement and
exploitative behaviors are common.

Adolescent sex offenders are prone to having a paraphilia. Deviant sexual fantasies which
reinforce victim selection are common features. While the majority of victims are female, some
studies postulate a connection with male victim choice and higher level of risk to re-offend.

Abuse of chemicals is considered a risk factor in a large portion of adolescent sex offenders.
Sexual abuse behaviors as well as issues with substance abuse must be treated concurrently.

Difficulties in school, including suspension and truancy, are common themes. Learning
disabilities, as well as a diagnosis of conduct disorder, are seen as risk factors for re-offense
behaviors.

Assessing an adolescent’s level of risk for sexual re-offense is imperative. No tool exists to
accurately say who will and will not re-offend. However, clinicians do have access to a variety
of risk estimation tools. Knowing an adolescent’s level of risk aids in the decision of treatment
intervention.

Clinicians working with adolescent sex offenders must address the risk factors of individual
adolescents in treatment planning. By targeting dynamic risk factors, including intensive family
therapy, adolescent sex offenders can lower their level of risk for re-offense.
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