

Juveniles Who Sexually Offend (J_wSO)

An Overview

FMHAC 2013

James Rokop Ph.D.
Private Practice
Davis, California

J_wSO Presentation Outline

The problem

The response

The myths

Theories

Typologies

Differentiating J_wSO from other offenders

Some characteristics identified

Assessment

Risk assessment

Treatment

Special population considerations

The National Center on Sexual Behavior of Youth (NCSBY), defines Adolescent Sex Offenders as “adolescents ages 13 to 17 who commit illegal sexual behavior as defined by the sex crime statutes of their jurisdictions.”

Juveniles Who Sexually Offend (J_wSO)

In the US, juveniles committed 15% of all forcible rape arrests reported in 2009, a decrease of 58% from its 1991 peak.

In 2010, juveniles were arrested for 14.4% of forcible rapes, 18.1% of all sex offenses (excluding rape and prostitution).

-Note that in 2012 revised definition of rape now includes any gender of victim or perpetrator

United States 2010 FBI Uniform Crime Reports, Lattaromasi & Miner, 2005, Lattaromasi et al., 2010

The Problem

Tougher Sentences

Out-of-home placement

Megan's Laws (1996)

Adam Walsh Protection and Safety Act (2006)

Sex Offender Registration Notification Act (SORNA)

Post-incarceration civil commitment

The Legal Response



By including children and adolescents in these laws, "states throw out a century of juvenile justice jurisprudence and scholarship to protect an even older tradition of fear about childhood sexuality." -Garfinkle (2003)

"A punitive approach to juvenile sex offender treatment, often accompanied by public humiliation, may only serve to alienate such adolescents further and hinder the normal social development that might otherwise contribute to the prevention of additional victims." -Parks and Bard (2006)

ATASA has noted that SORNA as applied to youth is contrary to the core purposes of our nation's juvenile justice system and will interfere with effective treatment and rehabilitation.

SORNA will decrease parental willingness to report or seek help for children's sexual behavioral problems.

The definition of aggravated sexual abuse (victims under the age of 12) will disproportionately place young offenders in the highest tier(s) and place more of them on the public registry...

Association of
the Treatment
of Sexual
Abusers (ATSA)

However...

- In United States v. Juvenile Male, the 9th circuit court held that the retroactive application of SORNA for former juvenile delinquents was punitive and constitutionally impermissible...
- Still need a congressional reassessment of SORNA's overall treatment of juveniles
- Better left to state legislatures which can advance more sensible policies

CA: Juvenile Sex Offender Registration

Juveniles adjudicated of certain offenses are required to register as sex offenders upon release from the California Department of Corrections and Rehabilitation, Division of Juvenile Facilities (Pen. Code § 290.08).

However, registrants whose offenses were adjudicated in juvenile court cannot be publicly disclosed on the Internet web site. Local law enforcement agencies may, in their discretion, notify the public about juvenile registrants who are posing a risk to the public (Pen. Code § 290.45).

State of California, Department of Justice,
Office of the Attorney General

Registration Qualifying Penal Codes

1. Assault with intent to commit rape, sodomy, oral copulation, or any violation of Section 264.1, 288, or 289 under Section 220.
2. Any offense defined in paragraph (1), (2), (3), (4), or (6) of subdivision (a) of Section 261, Section 264.1, 266c, or 267, paragraph (1) of subdivision (b) of, or subdivision (c) or (d) of, Section 286, Section 288 or 288.5, paragraph (1) of subdivision (b) of, or subdivision (c) or (d) of, Section 288a, subdivision (a) of Section 289, or Section 647.6.
3. A violation of Section 207 or 209 committed with the intent to violate Section 261, 286, 288, 288a, or 289.

CA WIC CODE § 781

In any case in which a ward of the juvenile court is subject to the registration requirements set forth in Section 290 of the Penal Code, a court, in ordering the **sealing of the juvenile records** of the person, also shall provide in the order that the person is **relieved from the registration requirement** and for the destruction of all registration information in the custody of the Department of Justice and other agencies and officials.

CA SVP LAW: WIC § 6600 (g)

(g) Notwithstanding any other provision of law and for purposes of this section, a prior juvenile adjudication of a sexually violent offense may constitute a prior conviction for which the person received a determinate term if all of the following apply: (1) **The juvenile was 16** years of age or older at the time he or she committed the prior offense. (2) The prior offense is a sexually violent offense as specified in subdivision (b). (3) The juvenile was **adjudged a ward of the juvenile court within the meaning of Section 602** because of the person's commission of the offense giving rise to the juvenile court adjudication. (4) The juvenile was committed to the **Department of the Youth Authority** for the sexually violent offense. (h) A minor adjudged a ward of the court for commission of an offense that is defined as a sexually violent offense shall be entitled to specific treatment as a sexual offender. The failure of a minor to receive that treatment shall not constitute a defense or bar to a determination that any person is a sexually violent predator within the meaning of this article.

Mens rea (guilty mind)

- Capacity to form intent

Doli incapax

- Incapable of criminal intention or malice

Parens Patriae

- States' legal role as guardian to protect the interests of children
- Has model shifted toward punishment?

Legal Principles Underlying Society's Treatment of Juveniles



Hunter & Lexier, 1998; Smallbone in Barbaree & Marshall, 2006

California Penal Code § 26

All persons are capable of committing crimes except those belonging to the following classes:

1. Children under the age of 14, in the absence of clear proof that at the time of committing the act charged against them, they knew its wrongfulness...

- 242 judges reviewed a forensic psychological report about a hypothetical defendant.
- Only the defendant's age and maturity level varied across reports.
- Perhaps not surprising, the older and more mature juveniles were deemed more competent.

What to Judges Think about Juvenile Competence?

Cox, J. Goldstein, N. Dolores, J. Zolichoski, A., Messenheimer, S. (2010)

Roper v. Simmons, [2005] The decision that made execution unconstitutional when the crime was committed when the perpetrator was under 18.

Graham v. Florida (2010), 130 S. Ct., expanded Roper. States brain science shows fundamental differences in juveniles. Parts of the adolescent brain continue to mature through late adolescence. Juveniles are more capable of change than are adults. There were all sorts of amicus briefs submitted by professional associations such as the APA and the ABA.

Steinberg, L. (2009). Should the science of adolescent brain development inform public policy? *American Psychologist*, 64(5), 739-750.

Cauffman, E., & Steinberg, L. (2000). (In) maturity of judgment in adolescence: Why adolescents may be less culpable than adults. *Behavioral Sciences and the Law*, 18(6), 741-760.

Grisso, T., Steinberg, L., Wechsler, J., Cauffman, E., Scott, B., Graham, S., Lexcen, E., Boppuck, M. D., & Schwartz, R. (2003). Juveniles' competence to stand trial: A comparison of adolescents' and adults' capacities as trial defendants. *Law and Human Behavior*, 27(3), 333-364.

Steinberg, L. (2003). Juveniles on trial: MacArthur Foundation study calls competency into question. *Criminal Justice*, 19(2), 29-36.

Steinberg, L., & Scott, E. S. (2003). Less guilty by reason of adolescence: Developmental immaturity, diminished responsibility, and the juvenile death penalty. *American Psychologist*, 58(12), 1009-1018.

Wolcott, R., Waggoner, J., Hyman, B., Hyman, C., & Caldwell, M. (2013, August 12). Juvenile offenders are ineligible for civil commitment as sexual predators. Presented at the 118th Annual Convention of the American Psychological Association, San Diego, CA.

The Myths



Three Faulty Assumptions

1. Juvenile sex offending is at epidemic levels
2. Juvenile sexual offenders have more in common with adult sex offenders than with other delinquents
3. Juvenile sex offenders are at exceptionally high risk for sexual recidivism

Letourneau and
Minor (2005)

The false notion that because many adult sex offenders report the onset of their behavior began in childhood or adolescence, most children with sexual behavioral problems and adolescent sex offenders will persist in commitment of adult sex crimes.

Logical fallacy of "backwards reasoning"

Chaffin (2011)

The transition from adolescent to adult sexual aggression is the exception rather than the rule.

J_wSO
Recidivism

Worling, Bookalam, & Littlejohn (2010);
Carpentier & Proulx (2011)

Most adolescent desist in their offending by adulthood -Caldwell (2010)

Juvenile sex offenders were 10 times more likely to engage in nonsexual than sexual recidivism. Caldwell (2007)

"A large majority of them will stop after their first registration as a sex offender. Of the remaining group, the majority displayed a broad range of delinquent behavior, in particular property crimes. Consequently, many VSOs are essentially juvenile offenders more than they are essentially sex offenders." -(Van Wijk et al. (2007)

J_wSO
Recidivism

Recidivism

Rates vary widely but have decreased in general

Worling and Langstrom (in Barbaree & Marshall, 2006)

- Review of 22 studies, with mean follow-up from 6 months to 9 years, range was 0% to 40%

Langstrom (2002)

- Average follow-up of 115 months, 30% recidivism

Hendriks & Bijleveld, 2004

- 60% for general recidivism, 10% for sexual recidivism

More highly sexualized

More sexual offenses

Less concerned about sexual misconduct compared to other JSOs

High Risk JSOs

Not deterred by consequences (possible civil commitment as SVP)

Hagan, Anderson, Caldwell, Kemper (2008)

J_wSO Who Sexually Offend as Adults

The mixed evidence concerning the progression from juvenile to adult sexual offending suggest that we do not fully understand the pathways of those who continue on to sexual offend and those who do not. -Hunter, Figueroa, Malamuth, & Becker (2004)

Boutwell et. al. (2013) found that life-course persistent (vs. adolescence-limited) offenders are disproportionately involved in acts of rape and sexual coercion. Genetic factors have been found to explain most of the variance for this group membership.

However, unlike general offending, an early onset to sexual offending does not appear to predict a life-course of sexual offending -Caldwell et al., (2008)

This is likely to be a highly select group (perhaps 10% according to Smallbone, Nisbet, Rayment, & Shumak, 2005) and early paraphilic offending may be one mechanism by which more serious offending stems.

Perhaps we are also talking about youth who have never been caught or sanctioned for their sexual offending behavior?

JSOs...

- Still developing (sexually, cognitively, morally etc.)
- Less sophisticated
- Less violent
- Lower recidivism rates
- Less entrenched patterns of sexual arousal and interest

ASOs...

- Tend to have a higher number of sexual abuse incidents
- Engage in more extrafamilial abuse
- Engage in more vaginal, anal, and oral intercourse, more use of coercion and persuasion
- Have more victims and longer relationships with victims.

Differences Between Adult (A_wSO) and J_wSO

Miranda & Corcoran, 2000; Caldwell, 2010; Letourneau & Miner, 2005; Prescott & Longo, 2006

J_wSO vs. Non-Sexual Offending Juveniles

- Younger at time of referral
- More poorly developed social skills
- Lower on extraversion
- Lower on impulsiveness
- Less truant
- More learning and behavioral problems
- More neurotic
- Less likely to report drug use
- Less likely to have a prior criminal history

van Wijk et al., 2005; Bijleveld & Hendriks, 2003; Miner & Munis, 2005; van Wijk, 1999; van Wijk, 2007

J_wSO vs. Non-Sexual Offending Juveniles

- Less extensive criminal histories
- Fewer antisocial peers
- Fewer conduct problems
- Fewer substance abuse problems
- More anxiety, low self-esteem
- More experiences of sexual abuse, physical abuse, emotional abuse, and neglect
- More early exposure to sex or pornography
- More atypical sexual fantasies, behaviors, or interests

Surprising Findings

- J_wSO did not differ from non-sex offenders across nine studies that reported antisocial attitudes and beliefs about sex, women, or sexual offending
- The 2 groups differed on measures of social isolation but no on measures of general social skills
- J_wSO were not significantly different on measures of antisocial personality traits despite being lower on antisocial behavior.

Seto & Lalumiere, 2010

J_wSO Heterogeneity

"As a taxonomic category, the term (adolescent sex offender) has virtually no value other than an administrative classification for crimes."

-Chaffin (2011)

J_uSO are not a well-defined taxonomy

Juvenile sex offending is typically part of a more varied criminal pattern

J_uSO are more likely to reoffend non-sexually

...In fact, 85% of all future sex crimes committed by the entire released juvenile delinquent population were committed by former non-sexual delinquents

J_uSO are heterogeneous along a number of dimensions including offending behaviors, histories of child maltreatment, social and interpersonal skills and relationships, sexual knowledge and experience, academic and cognitive functioning and mental health issues.

**JSO
Heterogeneity**

Letourneau & Miner, 2005; van Wijk, Mals, & Bullens, 2007; Caldwell, 2007 & 2010; Righthand & Welch, 2001

- Evolutionary Theories
- Behavioral Theories
- Social Learning Theories
- Personality Theories
- Meta-theoretical framework
- Physiological, neurological, or biological

Theories

- No single psychological theory
- No single cause
- Not even necessarily caused by sexual feelings

Theories

Ellis (2001)

"...safe is not better than sorry. In evolutionary terms, it is of no use being healthy and long-lived if this means exclusion from the mating game and, ultimately, the genetic future of the species."

Evolutionary Models



Brunkswikian Evolutionary-Developmental Model (2000)

- Inability to compete sexually in the "sexual marketplace" leads to the development of deviant strategies as a way of securing resources and status. Strategies may involve coercion.
- The etiology of sex offending could be seen as a cascade of failing strategies starting from psychosocial deficiencies and leading to sexual deviance to social deviance to sexual criminality.

Evolutionary Models

Behavioral and Social Learning

Classical and operant conditioning (reinforcement and punishment) may play a role in the developmental and maintenance of deviant sexual behavior.

Sex abuse may condition males physiologically (Worling, 1995)

Through self-regulation processes, sexual deviance can be incorporated through underregulation, misregulation, and intact regulation (Ward, Hudson, & Keenan, 1998)

Addiction model highlights the role of sexual behavior in reducing negative emotional states and bypassing self-coping processes thereby becoming habituated.

Social learning theory posits the abused-abuser hypothesis; some sexually abused children may learn to model the actions of their abusers.

Witnessing violent sexual material can lead to, or reinforce, sexual reoffending

Abuse-Abuser Hypothesis

- Seto & Lalumiere found through correlational analysis that group difference on sexual abuse was larger when the proportion of offenders against children among sex offenders was high and that sex offenders against children had been more often sexually abused than sex offenders against peers.
- History of sexual abuse is related to the onset of offending and not persistence (recidivism). -Hanson & Bussie're (1998); Hanson & Morton-Bourgon, (2005); Jespersen, Lalumiere, & Seto, (2009); van der Put et al. (2013)

Seto & Lalumiere (2010)

May be a specific developmental risk factor for pedophilia (see Lee, Jackson, Pattison, & Ward (2002).

Significant minority (e.g. 43%) of J_uSO undergoing treatment reported sexual victimization.

High percentages of prior sexual victimization associated with male child perpetration-Worling (2005)

J_uSO had 5 times the odds of having a history of sexual abuse compared to nonsexual adolescent offenders. -Seto & Lalumiere (2010)

Sexual Victimization

Attachment

Unstable or disorganized parent-child relationships are linked with the development of child antisocial behaviors (Smallbone, 2005)

Child sex offenders are less likely to have secure adult attachment styles

Maltreatment plays a prominent role

Non-normative sexual environment: Absence or denial of sexuality or a highly sexualized environment

Sexually coercive youth may have a parent background characterized by neglect, intrusive, rejecting, and abusive control.

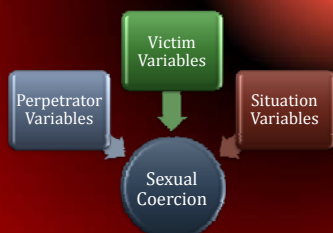
Recent Research (Adult sample)

- More likely to report insecure childhood attachment relationships with fathers (child sexual abusers)
- Child sexual abusers were more likely to report adult attachment insecurity
- High prevalence of insecure adult attachment (higher than prevalence of insecure childhood attachment)
- Transient attachment problems often precipitate sexual abuse behavior-1/2 of offenders reported experiencing relationship problems in the month preceding their onset offense and most used avoidance strategies (e.g. isolation, drug and alcohol abuse).

McKillop et al. (2012)

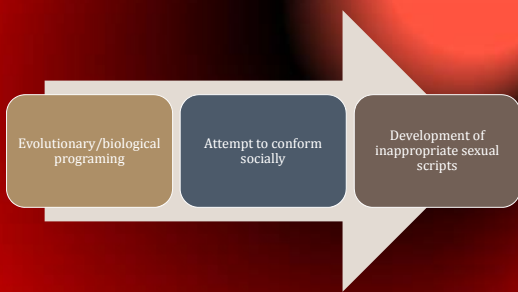
Ecological Theory

-a meta-theoretical framework for categorizing variables at the sociocultural, social network, dyadic, situational, and individual levels.



White & Kemmels, 1998

Integrated Developmental Model



Marshall and Barbaree, 1990

Biological, Genetic, and Neuropsychological Evidence

- IQ differences between J_{so}SO and non-sexually offenders have not reached statistical significance
 -However, J_{so}SO seem to have more learning problems or disabilities
- ADHD symptoms and neurodevelopmental deficits have been associated with sexually aggressive youth
- A history of traumatic brain injury has been found in delinquent samples
 - Research on adult sex offenders found that pedophilic patients reported significantly more head injuries before age 13 compared to non-pedophilic patients (Blanchard et al., 2003)

Pedophilia has been associated with familial transmission

Frontal-temporal impairment and verbal and language functioning impairments

Lower IQ's

Left handedness

Shorter stature

Less tissue in two wide-spread regions of the brain; the superior fronto-occipital fasciculus and the right arcuate fasciculus

Studies on Adults

Gaffney et al., 1984; Jorya et al., 2007; Cantor et al., 2005; Boger et al., 2011; Cantor et al., 2004; Cantor et al., 2007; Cantor et al., 2005

Many typologies exists

- personality based
- offense type
- victim age/gender
- level of aggression
- group vs. solo

JSO Typologies

JSOs can be consistently classified into 3 groups:

- Child
- Peer
- Mixed

Personality Based Typologies

Clinically Derived

- O'Brien & Bera (1986)-Naïve Experimenter, Undersocialized Child Exploiter, Pseudo-socialized Child Exploiter, Sexual Aggressive, Sexual Compulsive, Disturbed Impulsive

MMPI

- Smith, Monastery, & Deisher (1987)-1) Shy, emotionally overcontrolled, and isolated, 2) Narcissistic, disturbed, insecure, and argumentative, 3) Outgoing, honest, prone to violent outbursts, 4) Impulsive, mistrustful, and undersocialized

CPI

- Antisocial/Impulsive and Unusual/Isolated = high sexual and non-sexual recidivism - Worling (2001)

Psychopathy

Psychopathy is defined by a constellation of affective, interpersonal, and behavioral characteristics that include egocentricity; shallow emotions; lack of empathy, guilt, or remorse; a behavioral pattern of impulsivity; irresponsibility; lying and manipulating others; and the repeated violation of social rules and expectations (Hare, 1991).

Features of psychopathy have often been associated with persistent sexual offending in adult offenders, particularly when associated with sexual deviance.

Inconclusive evidence with J_{SO} using research on the PCL:YV due to methodological limitations

The construct itself maybe punitive and stigmatizing if applied to still developing youth

That being said, there are those rare juveniles who can display emerging traits consistent with a number of personality constructs including psychopathy

Type of Offense and Offending Background

Sex Offense Only Offenders:

- less risk for future delinquency, fewer behavioral problems in childhood, better social adjustment, more prosocial attitudes, victimized fewer unrelated victims, lower risk for delinquency than did the non-sex offender groups.

Sex Plus (nonsexual offending in background):

- resembled criminally versatile offenders, victimized more unrelated victims.

Sex Only Offenders

...might be seen more correctly as "experimenters": juveniles who happen to exceed the boundaries of their own sexuality, not because of any inner sexual deviancy, but as a consequence of "faulty experimentation." In other words, this concerns juveniles who are not yet fully aware of what is and what is not considered as sexually appropriate behavior. When it comes to sex-only delinquents, we are most probably partially dealing with "first offenders." – Van Wijk (2007)

Sex-Plus Offenders – Van Wijk (2007)

- Antisocial behavior includes committing sex offenses
 - Half begin their career with a sex offense
 - Percentage of sex offenses go down after first offense while property crimes increase
 - By 10th offense, almost half of committed a sexual assault
 - Sexual crimes form only a small part of a heterogeneous criminal career

Empirical

Pedophilic

- Lacked social skills
- Molested primarily females ≤ 3 years

Graves, Openshaw, Ascione, & Erickson (1996) Meta-analysis of 140 samples involving 16,000 adolescents who sexual offended...

Sexual Assault

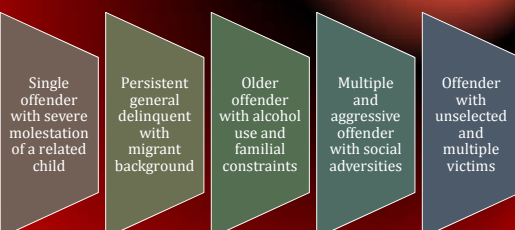
- Abused peers or older females

Undifferentiated

- Diverse offending
- No clear pattern of victim choice

Dimensional-Underlying Factors

- Abei et al. (2010)-performed exploratory principal component analysis to identify relevant patterns of sexual offending characteristics...



Victim Age, Relationship to Victim

Empirically Derived: Richardson, Kelly, Bhate, & Graham (1997)

- **Peer/Adult Group:** more likely to offend in public place, commit rape, abuse females, use weapon, belong to a delinquent peer group, most antisocial behavior, stranger victims.
- **Incest Group:** sibling victims, more abusive acts, longer abusive careers, both male and female victims, used authority and inducements, victims mostly in family home.
- **Mixed Group:** acquaintance victims, past adverse experiences, more abusive acts and longer abusive careers than peer/adult group, least discriminating with victim choice, poor academic performance, high rate of behavioral problems, at risk for child abuse or neglect, diverse offending locations.
- **Child Group:** acquaintance victims, 41% of victims male, higher rate of poor academic performance, high prevalence of being at risk for child abuse or neglect, abused many victims in surrogate home, less antisocial

Type of Offense

Prentky, Harris, Frizzell, & Righthand (2000)

- Child Molesters
- Rapists
- Sexually Reactive Children
- Fondlers
- Paraphilia Offender
- Unclassifiable

Group Rape Offenders

Bijleveld et al. (2007)

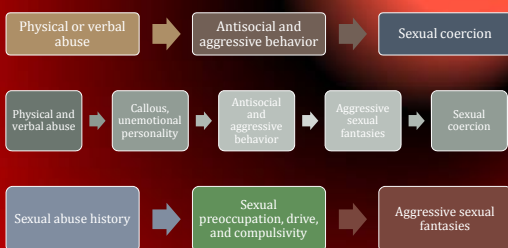
- Below average intelligence
- Average group size was 4
- Generally not planned
- In some cases offenders had agreed to have sex with a victim
- In other cases, offenders seemed to know what was going to happen without discussing it
- 1/3 of groups were leader orchestrated
- Group functioned as a public to the debasement of the victim
- Offense was regarded as entertainment
- In most cases, one vaginal rape took place
- In many cases the victim was threatened, even after completion of the offense

Empirical-Cluster Analysis

Hunter, Figueredo, Malamuth, & Becker (2004)

- **Early Adolescent Onset, Paraphilic**
 - highest rates of offending against male children
- **Life Course Persistent**
 - highest rates of self-reported non-sexual violence and the highest archival documented percent of arrests for non-sexual crimes, and the highest rates of offending against pubescent and postpubescent females.
- **Adolescent Onset, Nonparaphilic**

Knight & Sims-Knight 3 Path Model



Younger at time of offense

More likely to victimize related and male victims

More intrusive offending such as touching and masturbation of the victim

More likely to have social skills deficits

Lower in self-esteem

More apt to experience symptoms of depression and anxiety

More sexually preoccupied

Greater levels of deviant arousal (male victims, multiple victims, young victims and unrelated victims)

$J_w SO$
Who Target
Children

Archt et al., 2011; Gendry et al., 2010; Hunter, Figueredo, Malamuth, & Becker, 2003; Pardo & Bates, 2006; 2008; Rader, & Gendry, 2009

Hunter et al. (2003)

- Nearly half the adolescent sex offenders of prepubescent children met assessment criteria for clinical intervention for depression and anxiety. Central feature is social isolation (bullying, poor relations with peers).

Hendriks & Bijleveld (2004)

- Higher neuroticism scores
- Higher rates of psychopathology
- Preference for male victims
- little to no use of violence

Hunter, Hazelwood, Slesinger (2002)

- Offense more likely to occur in victims's residence

Van Wijk (2007)

- Least likely to use alcohol or other drugs

J_wSO
Who Target
Children

More likely to act in concert with co-conspirator

More likely to commit nonsexual offenses as well as sexual offenses

More antisocial

More prone to violence

More likely to offend in public places

Lower levels of sexual preoccupation

Higher proportion of female victims and strangers

Witnessed family violence more frequently

More likely to have criminally involved family members

J_wSO
Who Target
Peers

Richardson, Kelly, and Graham, 1997; Hunter et al., 2003; Gidycz et al., 2010

Something bold to consider...

- ...in a majority of cases, the sexual offense committed does not necessarily give an indication of any persistence in committing this kind of offense. It rather signals the beginning of a life of crime in general...
- ...The fact that a person commits a sexual offense and follows it up with other kinds of offenses should result in a person being registered as someone who commits a property crime or a crime of violence rather than as a sex delinquent.

-Van Wijk (2007)

Deviant Sexual Preferences
and Distortions

Abusers of Small Children

"Real Sex
Offenders" – Van
Wijk (2007)

Some who Assault/Rape

Where the Rubber Meets the Road- 2 Primary
Pathways



Assessment



Assessment

"Formal assessments are essential when formulating initial case management plans for sexually abusive individuals." - (Center for Sex Offender Management, 2007)

"Youth violence is multifaceted and risk should be evaluated across multiple domains." - (Viljoen, Elkovitch, Scalora, Ullman, 2009).

These include individual factors (personality, behavioral, cognitive, academic) and social context (family, peers, school, and community)

From a Risk-Needs-Responsivity (RNR) model, the assessment should also be individualized and address criminogenic needs (dynamic factors linked to criminal behavior) and strengths of the offender. - (Bonta & Andrews, 2007).

Assessment

Differences Between Adolescents and Adults

Adolescents are embedded as children within family and community systems subject to different set of rules, expectations, and obligations than adults.

Physically, cognitively, neurologically, psychologically developing

Far more influenced by developing biological, emotional, cognitive, and social systems, and the social environment in general, than adult behavior.

Stimulated, pleased, influenced, and motivated by different things

More experimental

Assessment involves understanding the systems within which children and adolescents live, learn, and function and on which they depend for structure, guidance, and nurturance.

Must understand social context of the child/adolescent

Reich, 2011

A Good Assessment Comes First

O'Callaghan (2006) has produced an assessment model specifically for intellectually impaired adolescents based upon detailed developmental and behavioral review which covers each of the nine areas outlined below:

- Family of Origin Factors
- Personal Health History
- Developmental History
- Care History
- Educational History
- Assessment of General Cognitive Functioning
- Social Functioning
- Psycho-Sexual History
- History and Meaning of Problematic Sexual Behavior:

The extent of the young person's appreciation of the general rules and conventions concerning sexual and interpersonal behavior.

The young person's ability to distinguish between acceptable and unacceptable sexual behavior.

Sexual experiences and influences, including sexual abuse

An evaluation of sexual interests

The opportunities the young person has to express their sexuality in a non-problematic manner

The understanding the young person has of the potential consequences for sexually abusive/offensive behaviours.

©Caldington (2002)

Assessment for DD/ID Offenders

Assessment

- Functional Behavioral Analysis-exploration of offense process
- Explore hopes for the future
- Evaluation of sexual interests and knowledge
- Exploration of social skills, emotional regulation, anger management, cognitive distortions, capacity for empathy
- Family/caregiver current strengths and concerns
- Psychometric testing
- Learning styles assessment

SO Assessment-Specialized Tools

- Visual Time
- Penile Plethysmograph
- Polygraph
- Attitudes/Beliefs Measures (sex, rape, empathy)
- Projective Tests
- Sexual Interest Card Sorts
- Treatment progress rating scales

Penile Plethysmograph

- Measures penile tumescence in response to various sexual and nonsexual stimuli and visual time measures, which examine viewing time in relation to slides varied by gender and age.
- Nine percent of both community and residential adolescent programs use the penile plethysmograph which appears to have been overtaken by the popularity of viewing-time measures.

Visual Time

Abel et al. (2004) evaluated the AASI with data collected from 1,704 males aged 11 to 17. The authors reported that VT for images of children was moderately correlated to the number of child victims ($r=.18$) and the number of acts of child sexual offending ($r=.23$). It was also noted that VT for child stimuli could moderately differentiate those adolescents who offended sexually against children from those who offended against peers or adults ($AUC=.64$).

Polygraph

Polygraphy is also used, primarily by programs in the U.S., to verify the offender's sexual history, details of specific concerns, and verify treatment and supervision compliance.

Polygraph

- Not common in Canadian programs
 - Don't require full disclosure
 - Less treatment overall (dosage)
- 50% of US programs use it.
 - Programs likely to require full disclosure for successful completion
 - Not been shown to reduce recidivism but may be other reasons to use it.

J_wSO Risk Assessment



Things We Think We Know (but are still not sure about when it comes to juveniles)

Risk prediction using unstructured clinical judgment is often not better than chance

Structured risk assessment procedures or tools increase accuracy and provide empirically supported treatment targets

Our ability to predict reoffending is still complicated by the "base rate" problem

We are mostly dependent on non-California samples when estimating risk to reoffend

- Youth violence is multifaceted, must evaluate risk across multiple domains
- Must consider social context (peers, family dynamics, community factors, prosocial involvement)
- Need to included individual factors
- Factors that are more static for adults are more dynamic for the adolescent offender
- Risk assessment with youth is extremely time-limited

Risk Assessment

Consider dynamic factors

Are more flexible and individualized

Follow principles of RNR, better for treatment considerations

Can be as or more predictive than actuarial tools depending on the study (SVR-20, HCR-20)

Can achieve moderate predictability when used as a mechanical

SPJ or Empirically Guided Approaches to Risk Assessment

Consider dynamic factors

Are more flexible and individualized

Follow principles of RNR, better for treatment considerations

Can be as or more predictive than actuarial tools depending on the study (SVR-20, HCR-20)

Can achieve moderate predictability when used as a mechanical

SPJ or Empirically Guided Approaches to Risk Assessment

Dynamic Factors

Dynamic = psychological risk factors

Dynamic factors can be stable, acute, or protective

Acute factors can be more idiosyncratic and represent a part of an offense cycle

Examples: anger, impulsivity, peer relationships, substance abuse, etc...

Static Factors

Unchangeable, historical

Think actuarial tools

Examples: age, gender, number of past sex offenses, etc...

North American Tools

- J-SOAP-II (Prentky et al., 2000; Prentky & Righthand, 2003)
- ERASOR (Worling & Curwen, 2001)
- J-SORRAT-II (Epperson et al., 2006)
- SAVRY (Borum et al., 2003)

UK

- AIM2 Framework (Print et al., 2007)

Current Popular JSO Measures

Most widely used NA tool

Designed as an actuarial, used as an empirically guided approach

Boys 12 to 18 with a history of sexually coercive behavior

28-checklist of factors

Static and dynamic factors

J-SOAP-II

Items on the J-SOAP-II are rated on a 0,1,2 scale, with a higher score representing greater risk.

A total score is then obtained by summing the items on the four scales.

Domains are evaluated for the ratio or percentage of items endorsed for that scale.

At the present time, there are no classifications associated with various total scores, and the J-SOAP-II functions as an "empirically informed guide" rather than an actuarial tool (Prentky & Righthand, 2003, p. 8).

J-SOAP-II

Sexual Drive/Preoccupation
prior sexual offense charges

Impulsive/Antisocial Behavior
past school behavior problems

Intervention
remorse and guilt

Community Stability/Adjustment
management of sexual urges

J-SOAP-II

- Mixed predictive validity results over several studies
- Sample variation seems to impact validity
 - Good prediction with highly victimized child welfare sample where recidivism was uniquely captured and the depth of records was impressive - Prentky et al. (2010)
- Most recent results, only scale 2 (Impulsive/Antisocial Behavior) was predictive of felony rearrests - Fanniff & Letourneau (2012)
- Singapore sample: not predictive of sexual recidivism but was predictive of nonsexual recidivism - Chu et al. (2012)

J-SOAP-II

Modeled after the SVR-20

Youth 12-18

25 risk factors

9 static and 16 dynamic factors

No protective factors

Items are coded as unknown, not present, possibly/partially present, or present

No cutoff scores, evaluators make an overall clinical rating or low, moderate, or high risk

ERASOR

Worling, Bookalam, & Litteljohn (2011)

ERASOR Research

- Worling (2004): total score and overall clinical ratings distinguished repeaters from nonrepeaters (AUCs of .72 and .66 respectively)
- Rajlic & Gretton (2010): total score and overall clinical ratings significantly predicted sexual recidivism (AUCs = .71 & .70 respectively)
- Viljoen et al. (2009): total score did not significantly predict sexual recidivism and the overall clinical rating only approached significance (AUC = .64)

ERASOR Research

- Encouraging results from a prospective research study of 191 J_wSO.
- Used multiple source recidivism data and a follow-up period between .1 and 7.9 years.
- Overall 9.4% recidivism rate
- Clinical judgment ratings, total score, and sum of risk factors rated as present were significantly predictive of sexual reoffending for the short follow-up period.
- Total score and sum of risk factors were predictive of sexual reoffending over the entire follow-up interval

Worling, Brinkman, & Lanthier (2012)

ERASOR-International Research

- Singapore sample of 104 male J_wSO
- ½ on probation, ½ were incarcerated at some point during their court orders.
- All had received sexual offender treatment during the duration of their court orders.
- Comparison of ERASOR, J-SOAP-II, and YLS/CMI
- ERASOR total score (AUC = .74) and overall clinical rating (AUC = .83) was the only one that significantly predicted sexual recidivism.
- All predicted nonsexual recidivism

Chen et al. (2012)

- Sexual Deviance
- Sexual Preoccupation
- Impulsivity
- Relationships
- Offense Management
- Supervision Compliance (ERASOR)
- Changes in Compliance with Supervision or Treatment (ERASOR)
- Changes in Sexual Preoccupation/Sexual Drive
- Changes in Victim-Related Behaviors (ERASOR)
- Changes in Emotional Coping (partial overlap J-SOAP-II)
- Changes in Social Relationships (partial overlap ERASOR)
- Changes in Victim Access (ERASOR)

J-SOAP-II and ERASOR Factor Overlap

Actuarial

Developed by identifying key predictors of sexual offending in a sample of 636 male youths who where adjudicated for a sex offense

12 items

12-18 at time of index sexual offense

Does include special education history

Numerical scoring

Has been cross validated in IOWA

J-SORRAT-II

Only 12 items

Items may or may not have conceptual meaning.

No protective factors

May be useful for base line risk in a convergent model

May be able to guide supervision or treatment level but not treatment needs

Utility of static measure for juveniles?

We don't really know how static items work for ID JSO offenders

J-SORRAT-II

More recently however, a meta-analytic direct comparison did find that the J-SORRAT-II, J-SOAP-II, ERASOR, as well as an adult actuarial tool, the Static-99, were all equally and moderately predictive of sexual recidivism in adolescent sex offenders. - Viljoen et al., (2012)

- Males 12-18 who are known to have sexually abused others on one or more occasions.
- Designed to assist early stage assessments of those with mainstream educational ability
- Four Domains
 - Sexually and Non-Sexually Harmful Behaviors
 - Developmental
 - Family
 - Environment
- Assesses static, stable dynamic, acute dynamic, and trigger factors
- 75 items are scored as low, medium, and high strengths and concerns.
- Assigns differential weighting of items with more or less empirical support
- Level of supervision required, "high, medium, or low management needs"
- Low IQ subjects were excluded


AIM2

- Has a lot to offer-probably the most comprehensive of all JSO measures.
- Allows for a Concerns and Strengths Profile
- Many of the items would appear to have relevance to ID offenders although it was not designed as such.
- More research support needed (revision 2007)
- Not clear how static items will continue to perform
- User friendly? (75 items)
- Clever but unsure about theoretical/empirical weighting system will continue to require revision

AIM2

Knight et al. (2009).

"It can also be argued that prediction per se should not be the role of risk assessment for JSOs. Multiple factors make prediction problematic for adolescents: (1) the plasticity of developing traits in adolescence; (2) the low base rates of sexual recidivism among children and adolescents (see, e.g., Caldwell, 2007, in press; McCann & Lussier, 2008; Waite et al., 2005); and (3) the low consensus on how to define predictors for adolescents (Miccio-Fonseca & Rasmussen, 2009)."



Recognition of protective factors should be an essential part of the risk management process and for interventions with high-risk adolescents to reduce re-offending.

Protective Factors

-Rennie & Dolan (2010)

AIM2

J-SOAP-II

SAVRY

SAPROF

Protective Factors/Strength Considerations

SAVRY

Protective Factors

Prosocial Involvement

Strong Social Support

Strong Attachment and Bonds

Positive Attitude Toward Intervention and Authority

Strong Commitment to School

Resilient Personality Traits

Referral behavior appears to be experimental (or non-abusive)	AIM2 Strengths/Protective Factors
Abusive behaviour appears to be peer influenced	
Abusive behavior ceased when the victim demonstrated non-compliance or distress	
Accepts responsibility for the referral offence	
Young person regrets having sexually offended	
Willing to address sexual behaviour problems	
Healthy physical developmental history	
Average/above average intelligence	
Positive talents and/or leisure interests	
Good negotiation/problem solving skills	
Developmentally appropriate level of sexual knowledge	
Positive realistic goals/plans	

Good Communication skills	AIM2 Strengths/Protective Factors
Grown up with consistent and positive relationship with at least one adult	
The most significant adults in a younger person's life demonstrate good protective attitudes and behavior	
The most significant adults in a young person's life demonstrate positive emotional coping strategies	
The most significant adult in young person's life have a positive support network	
The most significant adults in young person's life are generally healthy	
The young person uses at least one emotional confidant	
Positive evaluations from work/educational staff	
Positive relationships with professionals	
Young person feels emotionally and physically safe within their current environment	
Makes positive use of social support network	
Current caregivers/living environment can maintain appropriate level of supervision	

<u>Internal factors</u>		SAPROF
Intelligence		
Secure attachment in childhood		
Empathy		
Coping		
Self-control		
<u>Motivational factors</u>		
Work		
Leisure activities		
Financial management		
Motivation for treatment		
Attitude towards authority		
Life goals		
Medication		
<u>External factors</u>		
Social network		
Intimate relationship		
Professional care		
Living circumstances		
External control		
Vogel, Ruiter, Bouman, Vries Robbe (2009)		

Evidenced of Positive Support Systems

Stability of Current Living Situation

Stability in School

J-SOAP-II

Themes likely relevant to ID JSOs

Eager to Learn, Interest in Learning

Positive Attitude

Supportive/Stable/Prosocial person in life

Positive relationship with guardian, parent, and/or staff

Has leisure interests and participates

Personal boundaries

Treatment Compliance/Motivation/Participation

Protective Factors-DD/ID JSOs

Incorporation of Protective Factors

Summary-Risk Assessment

- Tools are early in development
- More research, cross validation and item refinement
- Tools are not adequately capturing developmental and risk differences among adolescent age subgroups
- Identification of persistence factors needed
- Relevant risk and need factors for:
 - intellectually or developmentally delayed offenders
 - female adolescent sexual offenders
- Need to identify which protective factors most relevant to juvenile sex offending and balance these with risk in an intelligent way
- Dynamic factors are essential
- Don't forget about unique factors?
- Don't forget to ask the obvious questions...

Treatment



Treatment-Historical Overview

- 1986 - 9 programs
- 2003 - 937 programs
- 2009 - 494
 - 26% residential
- 2000
 - Average length of treatment for community-based programs ranged between 12-24 months for adolescents and 6-12 months for children
- 2003
 - 1/3 of programs were using one or more of the following treatments for sexual deviance: aversive behavioral rehearsal, covert sensitization, masturbatory satiation, odor aversion and minimal arousal conditioning
- 2009 Common Canadian Core treatment targets - Ellerby et al. (2009)
 - Victim awareness and empathy
 - Intimacy/relationship skills
 - Problem solving
 - Social skills
 - Family support
 - 1/4 use medications like SSRIs to treat sexual arousal control and sexually obsessive thoughts

The Good News

Treatment does appear to work and lowers risk

- Worling, Littlejohn, & Bookalam (2010)
 - Large, longitudinal study (12-20 follow-up) concluded that specialized treatment led to significant reductions in both sexual and nonsexual recidivism
- Treatment completion is meaningful and has been associated with recidivism reduction in adult and juvenile sex offenders* Edwards et al., 2005; Hanson and Bussier, 1998)
 - Adolescent and children's programs have slightly higher completion rates than adult programs and Canadian programs have the highest completion rates

Factors that Predict Treatment Failure

- "Mixed" Offenders ("undifferentiated")
- ERASOR Factors —Edwards et al. (2005)
 - Attitudes supportive of sexual offending
 - Interpersonal aggression
 - Unwilling to alter deviant interests/attitudes
 - Ever had a male victim

Treatment Shift

OLD SCHOOL

- 1980s/90s overly focused on role of deviant sexual interests
 - Fantasy logs, covert sensitization
- Downward extension of adult programs
- Didn't take into consideration developmental issues, learning styles, or impact of trauma
- Relapse prevention (decreasing popularity yet still a top 3 theory/model along with CB and family systems)

Longo & Prescott, 2006; Righthand et al., 2006

Treatment Shift

NEW SCHOOL

- Now recognized that most adolescents who commit a sexual offense do not display primarily deviant sexual interests
- A focus on general criminality
- Offender sexual interests and details of past sexual crimes should occur in individual vs. group sessions
- Other factors to consider including intimacy deficits, antisociality, attitudes supportive of offending, and opportunity
- Short term interventions may be more effective
- Match length of treatment to level of risk
- Focus on dynamic factors of risk
- Good therapy is good sex offender therapy; good therapists can make good sex offender therapists
- Victim empathy more important than general empathy
- Good lives models and self regulation models replacing tradition RLP approaches
- Risk Needs Responsivity focuses treatment on criminogenic treatment targets
- Cognitive behavioral therapies may be supplemented with more individualized and holistic approaches
- Research on MST (18.7% of U.S. programs) has encouraged more evidenced based approaches and need for a comprehensive, family, and community-based emphasis
- Developmentally sensitive approaches
- Consideration of learning styles
- Impact on trauma

Knight et al. (2009)

...Sexual offender treatment programs for both juveniles and adults that target the major criminogenic needs and adhere to the risk-needs-responsivity principles of Andrews and Bonta (2007) have been found to show the largest reductions in both sexual and general recidivism (Hanson, Bourgon, Helmus, & Hodgson, 2009).

The risk principle is founded on research demonstrating that treatment interventions are most effective when they match the level of reoffending risk presented by an individual. In other words, people who present a significant risk of reoffending, ideally assessed by validated assessment measures, require the most intensive and extensive services. In contrast, individuals assessed as low-risk require minimal or even no interventions.

The Risk Principle

Andrews & Bonta, 2006

Research results also have demonstrated that interventions are most effective when they address those factors that are associated with reoffense risk or what is commonly referred to in the criminology literature as "criminogenic needs." Said another way, the need principle helps providers decide "what" types of problems to treat.

The Need Principle

Andrews & Bonta, 2006

In accordance with the responsivity principle, programs should be offered in a format in which individuals can most successfully respond. The responsivity principle focuses on "how" to deliver services. Broadly, programs delivered using a cognitive-behavioral format appear to be the most effective for adults and some adolescents.

Specific responsivity issues concern delivering services that match such areas as an individual's motivation, intellectual abilities, gender, culture, and personality characteristics. In addition, programs that encourage and facilitate involvement of the client's natural support systems generally appear to be most effective with many adolescents and children.

The Responsivity Principle

Hanson et al. 2009; Reitzel & Carbonell, 2006; St. Amand et al. 2008

Being Healthy

Having Fun & Achieving

Being My Own Person

Having Purpose and Making a Difference

Having People in My Life

Staying Safe

G-MAP's List of Primary Needs

- Identifying primary needs
 - What need was trying to be met through offending
- Identifying the young person's predisposing factors to offend (internal and external)
- Formulation of a Good Life Plan
- Identifying strengths and limitations in attaining means
- Intervention plan
- Negotiating Good Life Plans with young people
- Ensuring that GLP are developmentally appropriate

G-MAP & Good Lives Model (GLM)

Antisocial J_wSO

- General Corrective Approach, General Delinquency Factors
- Education, Cultural Differences in the Areas of Sexuality
- Maintaining Relationships with Opposite Sex
- Negative Peer affiliations
- Multisystemic-address individual, familial, and social influences
- Addressing general delinquency dynamic factors in JSO's may reduce general and sexual recidivism —van Der Put et al. (2013)

Sex Only J_wSO

- Sexual Interests and Behaviors
- Personal and situational factors that increase likelihood of re-offense
- Social isolation
- Sexual trauma treatment
- Sex education
- Specialized interventions and treatments for sexual deviance

Residential vs. Community Treatment

No empirical way to systematically classify juvenile sex offenders from least restrictive to most restrictive treatment settings.

Some possible considerations:

- Numerous offenses
- Aggression used during the offense
- Severe emotional and behavioral problems
- Antisocial attitudes
- Poor motivation for treatment
- Volatile family relations
- Suicidal ideation
- Continued sexual acting out under supervision or in lower level residential care
- Risk to public
- Family dysfunction/constellation
- Family attitudes about risk
- Lack of community resources

Bourke and Donohue (1996)

Special Populations-Female J_w SO

Special Populations-Female J_w SO

Underrepresented in the sex offending population

Less likely to be reported

Less likely to be aggressively pursued with child welfare, criminal justice, or juvenile justice systems

Research limitations, males asked about perpetration, females asked about victimization

We only have descriptive information at this point

Special Populations-Female J_WSO

Characteristics

- Younger at time of arrest, younger victims than male counterparts
- High prevalence of extensive, severe sexual victimization (victimized at younger ages and more likely to have multiple perpetrators)
- Distorted beliefs about the victim (e.g. victim deserved it) and physical aggression (legitimate response)
- Experience environments with poorer sexual boundaries
- Instability and dysfunction within the family and home
- Co-occurring psychiatric disorders including PTSD
- Victimization of younger children within the family or who are familiar
- Targeting victims of either gender
- Acting alone, often offending within the context of care-giving activities
- Most acts are non-aggressive. Rape is more rare but more likely to involve same gender victim
- Don't exhibit exclusive sexual attractions to young children
- Use of coercion was a function of the age at which they experienced their own sexual abuse - Roe-Sepowitz & Krysiak (2008)

Center for Sex Offender Management
(2007); Kubik & Hecker (2005)

Special Populations-Female J_WSO Typology

Typology 1

- Offended non-related child, limited number of incidents, inexperienced, naive, fearful of sexual matters, motivated by experimentation or curiosity. Histories of maltreatment, family dysfunction, and psychological difficulties were limited.

Typology 2

- Sexually reactive, abuse of younger siblings in a manner that mirrored own victimization, non-severe psychological difficulties, adequate social skills, and other personality traits.

Typology 3

- More extensive and repetitive sex offending behaviors, greater levels of emotional and psychosexual disturbance. Many had experienced considerable developmental trauma, including sexual victimization often beginning at an early age.

Mathews, Hunter, & Vuz (1997)

Special Populations-Female J_WSO

Treatment Targets

- Establishing and maintaining trusting, supportive, and equitable intimate relationships
- Promoting autonomy and self-sufficiency
- Developing a positive self-concept
- Enhancing assertiveness and social competency;
- Increasing effective emotional management;
- Reducing self-destructive/self-injurious behaviors; and
- Ensuring healthy sexual development, expression, and boundaries.
- Addressing issues of trauma and treatment of co-morbid psychiatric conditions
- Using additional collaborative partners which may include school personnel, family therapists, and mentors

Center for Sex Offender Management
(2007)

Special Populations-Female J_wSO

Risk Factors

- Sexual and physical victimization
- Dysfunctional family
- Parent/child relationship difficulties
- Antisocial peers
- Academic failure
- Pregnancy
- Early onset of puberty
- Mental health difficulties
- Substance abuse

Center for Sex Offender Management
(2007)

Special Populations-Female J_wSO

- No empirically validated risk tools available
- No empirically supported treatment programs, case-by-case basis

Is there a need for special treatment and tools???

Fact Sheet, National Center on Sexual Behavior of Youth (2004)

Special Populations-Developmentally Delayed (or ID) J_wSO

"To date the specific needs of young people with intellectual disabilities have received limited attention in the literature devoted to adolescents who sexually harm"-O'Callaghan (2006).

Prevalence: Developmentally Delayed (or ID) J_wSO

Not so clear...

Gilby, Wolf, & Goldberg (1989) found no significant difference between ID and Non-ID youth in regard to overall frequency of sexual behavioral problems.

...Yet, increased research has shown that ID JSOs are responsible for more sexual offending than previously acknowledged-Dolan, Holloway, Bailey & Kroll, 1996; Timms & Goreczny, 2002

Knopp & Lackey (1987) in Ryan, Leversee, & Lane, (2010) identified 3,355 offenses committed by slightly more than 1,500 ID adults and adolescents.

Learning Disordered
Developmental Delays
Borderline IQ
Mental Retardation

Who Are DD J_wSO?

J_wSO tend to have more learning problems than non-sexual offending adolescents

Some research supports that J_wSO exhibit average to low-average IQ

Construct Overlap?

Defining DD/ID

In the UK context the definition of developmental impairment is defined as:

A significantly reduced ability to understand new or complex information, to learn new skills and impaired intelligence (an IQ measurement of 70 or below), plus Reduced ability to cope independently (impaired social functioning) which started before adulthood and has a lasting effect on development

(Department of Health, 2001 in O'Callaghan, 2006).

Defining DD/ID

Borderline intellectual functioning

IQ between 70-80 with adaptive functioning deficits

Intellectually disabled (i.e., cognitive impairment that arose before the age of 18 which is reflected by an IQ core below 70 and have adaptive functioning deficits

Defining DD/ID DSM-IV TR

Mild to moderate mental retardation, IQ 50 to 70

Plus evidence of adaptive functioning deficits (communication, self care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

DSM-IV TR Borderline Intellectual functioning (IQ 71 to 84)

Similarities between DD/ID and Non-DD/ID Offenders

Both commit multiple offences of different forms

Equally likely to engage in assaultive sexual behaviors

Have histories of school problems, social deficits, behavioral problems and family dysfunction

Both experience discrimination

Unique Characteristics of Juvenile DD/ID Offenders

Low specificity for gender and age of their victims and offense type

May tend to target victims under age of 12

More likely to engage in nonassaultive/noncontact behaviors such as public masturbation, exhibitionism, and voyeurism

Sexual naïveté

More severe social skills/relationship deficits

Less insight

Poorer judgment

More concrete

More prone to impulse control difficulties

May have other learning disabilities or medical issues

May interpret normative sexual behaviors as unacceptable

Unique Characteristics of Juvenile DD/ID Offenders

May tend to under-respond to offensive or abusive sexual conduct

Offense may be more opportunistic

Victims are more likely to be someone known or youth has observed. If victim is a stranger, it is more likely to occur in situations that are part of the youth's daily routine.

At times may misjudge ability to control victim

More repetition in either who they abuse or where they abuse

Limited sexual education

Denied the social context that enables healthy sexual expression within peer group

Lack of opportunity to experience normative sexual interactions with peers

Denial and repression of all sexuality by caregivers

Lack of privacy

Unique Characteristics of Juvenile DD/ID Offenders

Likely to experience even more discrimination

Guilt and shame at being disabled

More abuse in their backgrounds, more risk for abuse

More compliance issues

Cognitive problems:

- low intellectual functioning, slower processing speed, working memory deficits, limited vocabulary, expressive language and comprehension difficulties.

Treatment takes longer

More dependent on adult supervision, guidance, and direction

Independent functioning a greater focal point of treatment

Guardian takes on responsibilities

Unique Characteristics of Juvenile ID Offenders

Sexual behaviors may reflect a number of non-sexual needs

Attention seeking; evidence of distress; avoidance of undesired demands; controlling behaviors; and under-stimulation.

Interpretation may be particularly difficult in more significantly disabled individuals with communication impairments.

Notion of Counterfeit Deviance

Hingsburger et al. (1991) and Luiselli (2000) noted that the term "counterfeit deviance" refers to behavior which is undoubtedly deviant, but may be precipitated by factors such as:

1. lack of sexual knowledge,
2. poor social and heterosocial skills,
3. limited opportunities to establish sexual relationships
4. sexual naiveté

Examples of items complicated by ID:

Attitudes supportive of sexual offending

Unwillingness to alter deviant sexual interests/attitudes

Ever assaulted a male victim

Indiscriminate choice of victims

No development or practice of realistic prevention plans/strategies

Incomplete sexual-offense-specific treatment

ERASOR

Examples of items likely complicated by ID:

Accepting responsibility for offenses

Understands risk factors and applies risk management strategies

Empathy

Remorse and guilt

Cognitive distortions

J-SOAP-II

Resources

- Association for the Treatment of Sexual Abusers
- California Coalition on Sexual Offending
- Center for Sex Offender Management
- International Association for the Treatment of Sexual Offenders
- National Center on Sexual Behavior of Youth
- National Institute of Justice
- American Professional Society on the Abuse of Children
- National Institute of Justice
- Safer Society Foundation, Inc.
- STOP IT NOW!
- The Child Abuse Prevention Network
- Public Safety Canada
- NEARI Press
- Sage Publications

CA WIC CODE § 781

In any case in which a ward of the juvenile court is subject to the registration requirements set forth in Section 290 of the Penal Code, a court, in ordering the sealing of the juvenile records of the person, also shall provide in the order that the person is relieved from the registration requirement and for the destruction of all registration information in the custody of the Department of Justice and other agencies and officials.

Adolescent Sex Offenders

Doug Boer and James Rokop

Introduction

The label, Adolescent Sex Offender, is burdened with preconceptions and is least harmfully and most accurately viewed as an administrative classification for crimes (Chaffin, 2008, pg. 117). In the United States (U.S.), juveniles committed 15% of all forcible rape arrests reported in 2009. However, rates of sexually offending are declining. According to the U.S. Department of Justice, the forcible rape arrest rate has fallen 58% from its 1991 peak, the lowest in three decades. Seemingly at odds with this downward trend, there has been a significant departure from the way in which juvenile offenders have been traditionally handled by the juvenile justice system in some countries. For example, in the U.S., Megan's Law (1996), the Adam Walsh Protection and Safety Act of 2006, and the federal Sex Offender Registration Notification Act (SORNA) are examples of tough laws with the goal of unified registration and public notification of all sex offenders. Adolescent sex offenders can even face possible post-incarceration civil commitment (Nguyen & Pittman, 2011). The premises of these laws are built on faulty assumptions (Letourneau & Miner, 2005), evidence of a deterrence effect is lacking (Letourneau, Bandyopadhyay, Armstrong, & Sinha, 2010) and the treatment community appears to have little confidence that these laws enhance public safety (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010).

The Heterogeneity of Adolescents who Sexually Offend

The label, adolescent sex offender, denotes a well-defined taxonomy that is in fact, misleading. Adolescent sex offenders tend to be more similar to other adolescent offenders (Letourneau & Miner, 2005) and sexual offending typically only forms one aspect of a more varied criminal pattern (van Wijk, Mali, and Bullens, 2007). These offenders are also many times more likely to reoffend nonsexually (Caldwell, 2010) and are heterogeneous along a number of dimensions including types of offending behaviors, histories of child maltreatment, social and interpersonal skills and relationships, sexual knowledge and experiences, academic and cognitive functioning, and mental health issues (Righthand & Welch, 2001).

Characteristics of the Adolescent Sexual Offender

Theories on sexual offending include those from evolutionary, biological, cognitive, behavioral, personality, social learning, self-regulation, and attachment perspectives (for a review of theories on sexual offending see Ryan, Leversee, & Lane, 2010 and Stinson, Sales, & Becker, 2008). Integrative theories, for example, Marshall and Barbaree's (1990) Integrated Developmental Model and Stinson, Sales, and Becker's (2008) Multimodal Self-Regulation Theory, attempt to integrate concepts from several models and offer a developmental perspective.

Although heterogeneous, characteristics of the adolescent sex offender have been identified through direct comparisons with their non-sexual offending adolescent counterparts. In Seto and Lalumiere's (2010) meta-analytic study of 59 independent studies, it was found that adolescent sex offenders had less extensive criminal histories, fewer antisocial peers, fewer conduct problems (when using sources other than self-report) and fewer substance abuse problems. They also reported more psychopathology in the form of anxiety and low self-esteem, and more experiences of sexual abuse, physical abuse, emotional abuse, and neglect. Those who offend children were more often sexually abused than sex offenders against peers. Adolescent sex offenders also reported more early exposure to sex or pornography and reported more atypical sexual fantasies, behaviors, or interests, or were more often diagnosed with a paraphilia. Surprisingly, the authors found that adolescent sex offenders did not differ from non-sex offenders across nine studies that reported antisocial attitudes and beliefs about sex, women, or sexual offending. Another surprising finding was that adolescent sex offenders were not significantly different on measures of antisocial personality traits despite being lower on measures of antisocial or criminal behavior. Interestingly, the authors also found the two groups differed on measures of social isolation but not on measures of general social skills.

Clinical and empirically-derived typological research has also highlighted the unique characteristics of different adolescent sexual offender subgroups. It has been found that adolescent sex offenders can be consistently classified into three groups; child, peer, and mixed (Kemper & Kistner, 2007) suggesting different etiologies (Gunby & Woodhams, 2010) that may be important to consider in treatment planning (Aebi, Vogt, Plattner, Steinhausen, & Bessler, 2011).

Adolescent sexual offenders of children versus peers and adults have been shown to be younger at the time of the offense, more likely to victimize related and male victims, engaged in more intrusive offending such as touching and masturbation of the victim (Aebi et al., 2011), more likely to have social deficits, lower in self-esteem (Gunby et al., 2010), more apt to experience symptoms of depression and anxiety (Hunter, Figueredo, Malamuth, & Becker, 2003), and are more sexually preoccupied (Parks & Bard, 2006). Those with male child victims in particular, display the greatest levels of deviant arousal (Clift, Rajlic, & Gretton, 2009).

Research on adolescent sex offenders who target peers and adults have found that they are more likely to act in concert with a co-conspirator and commit nonsexual offenses in conjunction with their sexual crimes (Richardson, Kelly, and Graham, 1997) are more antisocial (Hunter et al., 2003), exhibit a relatively low level of sexual preoccupation, and have a higher proportion of female victims and strangers (Richardson et al., 1997). Consistent with social learning theory, these offenders have also witnessed family violence more frequently and are more likely to have criminally involved family members (Gunby et al., 2010).

Assessment

Formal assessment is critical for understanding and treating the adolescent sex offender (Center for Sex Offender Management, 2007) and risk should be evaluated across multiple domains (Viljoen, Elkovitch, Scalora, Ullman, 2009). Individual factors (personality, behavioral, cognitive, academic) and social context (family, peers, school, and community) should be

considered and the common presence of neurodevelopmental disorders may suggest the need for additional assessment competencies among professionals (Fago, 2003).

According to principles underlying the risk needs responsivity (RNR) model, assessments should also be individualized and address criminogenic needs (dynamic factors linked to criminal behavior) and strengths of the offender (Bonta & Andrews, 2007). Some programs also utilize psychophysiological instruments to assess for the presence of deviant arousal and sexual interest (McGrath, R., Cumming, G., Burchard, B., Zeoli, S., & Ellerby, L., 2010). These instruments include penile plethysmography, which measures penile tumescence in response to various sexual and nonsexual stimuli and visual time measures, which examine viewing time in relation to slides varied by gender and age. Polygraphy is also used, primarily by programs in the U.S., to verify the offender's sexual history, details of specific behavioral concerns, and to verify treatment and supervision compliance.

Risk Assessment

Risk assessment with adolescent sex offenders has evolved over time but still lacks refinement, empirical support, and the ability to make precise probabilistic estimates of sexual and nonsexual recidivism (Worling, J. R., Bookalam, D., & Litteljohn, 2011). It has been argued that the goal of adolescent risk assessment should be prevention, treatment, case management, and supervision versus prediction (Olver, Stockdale, & Wormith, 2009). This appears further justified by the low overall rates of sexual re-offense among adolescents (Caldwell, 2010).

Although risk factors that predict adult sexual re-offense can predict sexual re-offense in adolescents (Hanson & Morton-Bourgon, 2004; Viljoen, Mordell, & Beneteau, 2012), it remains unclear if adult sex offender risk factors and tools should be utilized. Most adolescents desist in their offending by adulthood (Caldwell, 2010) and the fluid nature of adolescent offending warrants a developmentally sensitive, flexible (Viljoen, et al., 2009; Vitacco et al., 2009), and dynamic approach as well as the need for shorter reassessment intervals (Olver et al., 2009). Furthermore, additional factors such as peer group associations, family dynamics, involvement in conventional pursuits, and community factors should be considered (Righthand and Welch, 2004).

According to the most recent Safer Society 2009 North American Survey (McGrath et al., 2010), three structured risk assessment instruments, the ERASOR (Worling & Curwen, 2001), the J-SOAP-II (Prentky & Righthand, 2003), and the JSORRAT-II (Epperson, Ralston, Fowers, & DeWitt, 2006) were the most commonly used risk assessments for adolescent male juvenile sex offenders between the ages of 12 to 18. The J-SOAP-II and the ERASOR represent empirically guided or structured professional judgment approaches while the J-SORRAT-II is an actuarial measure.

Actuarial approaches like the J-SORRAT-II are comprised of factors correlated with sexual re-offense that are static or historical in nature. These approaches can provide risk estimates based on group comparisons with known recidivists. Although easy to use, some controversy in the adult literature surrounds the appropriateness of their use in the prediction of an individual's risk of re-offense (for a discussion see Cooke & Michie, 2010 and Hanson, Howard, 2010). They also lack comprehensiveness and the ability to address case-specific factors (McGrath et al.,

2010) and the effects of base rate variability may impact their predictive accuracy (Sreenivasan, Weinberger, Frances, & Walker, 2010).

Empirically guided approaches include dynamic factors essential for measuring treatment progress and changes to risk level (Vincent, Chapman, and Cook, 2011). Unlike actuarial scales, these approaches do not utilize numerical scoring to determine a specific probability of a re-offense and the final risk determination remains a clinical judgment. Studies examining the predictive validity of adolescent instruments, however, have shown mixed results and using more than one instrument may be desirable (Elkovitch, Viljoen, Scalora, & Ullman, 2008). The mixed results may be due to a variety of factors including sample variation, low re-offense rates, and the heterogeneity of adolescent sex offending. More recently however, a meta-analytic direct comparison (Viljoen et al., 2012) did find that the J-SORRAT-II, J-SOAP-II, ERASOR, as well as an adult actuarial tool, the Static-99, were all equally and moderately predictive of sexual recidivism in adolescent sex offenders.

Despite the advances in adolescent risk assessment, current methods appear to require further cross validation and item refinement. Tools are also not adequately capturing developmental and risk differences among adolescent age subgroups, persistent factors that may predict adult sexual offending, protective factors specific to adolescent sex offenders, and relevant risk and treatment factors for intellectually or developmentally delayed offenders and female adolescent sexual offenders.

Treatment

Specialized sex offender treatment appears effective in lowering risk (Reitzel & Carbonell, 2006) for both sexual and nonsexual offenses even after long-term follow-up (Worling, Littlejohn, & Bookalam, 2010).

Cognitive behavioral theories remain the most widely used theories defining most programs although some programs have evolved to become more individualized and holistic (Bengis & Cunningham, 2006). The relapse prevention model has decreased in popularity likely because of criticisms about its unitary pathway approach, overemphasis of avoidance versus approach goals and lack of empirical support (Ellerby, L., McGrath, R. J., Cumming, G. F., Burchard, B. L., Zeoli, S., 2010). Models that appear to be slowly replacing relapse prevention include self-regulation, risk needs responsivity (RNR), and the good lives model (GLM). The proven effectiveness of multisystemic therapy has also encouraged the development of evidence based treatments for treating adolescent sex offenders (Letourneau et al., 2009). Although currently in use by only a minority of North American programs (McGrath et al., 2010), treatment and management is considered to be most effective when following the principles of the risk-need-responsivity model (Bonta & Andrews, 2007) which encourages the assessment of criminogenic needs and individual ability and learning-related factors for treatment planning and dosage.

Interventions with adolescent sex offenders should be developmentally sensitive and address time periods when risk is higher. Cognitive changes, hormonal changes, the role of family and peers, judgment, impulse control, bonds to school and other pro-social groups, and the response to social stressors like child abuse may play a role in repeated adolescent sexual offending

(Caldwell, 2010). Despite varying levels of empirical support, Ellerby et al, (2010) found that the most common treatment targets for Canadian adolescent and child programs included victim awareness and empathy, intimacy/relationship skills, problem solving, social skills, and family support networks. In 2009, one quarter of Canadian adolescent male programs also used medications to treat sexual arousal control problems and sexually obsessive thoughts (Ellerby et al., 2010). In the U.S., over half of programs for adolescent males also use one or more behavioral sexual arousal control techniques with covert sensitization being the most popular.

Adolescent and children's programs have slightly higher completion rates than adult programs (Ellerby et al., 2010) and treatment completion is a meaningful concept that has been associated with sex offender recidivism (Hanson and Bussier, 1998). Factors that influence treatment amenability and failure include being a "mixed" offender (victimized both children and peers/adults), impulsivity, age (older), unsupportive parenting, and unwillingness to alter deviant sexual interests/attitudes (Kemper & Kistner, 2007; Parks & Bard, 2006; Kraemer, Salisbury, & Speilman, 1998; & Kimonis, Fanniff, Borum, Elliott, 2011).

Summary

Adolescent sexual offenders are best described as a heterogeneous population most similar to their non-sexual offending peers with some unique characteristics that may warrant further consideration through individualized and comprehensive assessment and treatment. General antisociality and atypical sexuality remain the primary pathways to offending. A comprehensive, multimethod, and multimeasure approach to assessment continues to be warranted given the diversity of offending etiologies. The development of reliable and valid risk assessment procedures and tools is still evolving as are treatment approaches that increasingly rely on empirical support, the individualized needs of the offender, and greater understanding and incorporation of the ecology that contributes to adolescent sexual offending. Populations of offenders that continue to warrant further study with regard to assessment, risk, and treatment include female and developmentally delayed adolescent sexual offenders.

References

- Aebi, M., Plattner, B., Steinhausen, H.-C., Bessler, C. (2011). Predicting sexual and nonsexual recidivism in a consecutive sample of juveniles convicted of sexual offences. *Sexual Abuse: A Journal of Research and Treatment*, 23(4), 456-473.
- Bengis & Cunnigim, (2006). Beyond psychology: Brain-based approaches that impact behavior, learning, and treatment. In R. E. Long & D. S. Prescott (Eds.), *Current perspectives: Working with sexually aggressive youth & youth with sexual behavior problems* (pp. 45-62). Holyoke, MA: NEARI Press.
- Bonta, J., & Andrews, D. A. (2007). *Risk-need-responsivity model for offender assessment and treatment* (User Report No. 2007-06). Ottawa, Ontario: Public Safety Canada.
- Center for Sex Offender Management (2007). *The importance of assessment in sex offender management: An overview of key principles and practices*. Silver Spring, MD: Author.
- Caldwell, M. F. (2010). Study characteristics and recidivism base rates in juvenile sex offender recidivism. *International Journal of Offender Therapy and Comparative Criminology*, 54(2), 197-212.
- Chaffin, M. (2008). Our minds are made up--don't confuse us with the facts: Commentary on policies concerning children with sexual behavior problems and juvenile sex offenders. *Child Maltreatment*, 13(2), 110-121.
- Clift, R. J., Rajlic, G., Gretton, H. M. (2009). Discriminative and predictive validity of the penile plethysmograph in adolescent sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 21, 335-362.
- Cooke, D. J., Michie, C. (2010). Limitations of diagnostic precision and predictive utility in the individual case: A challenge for forensic practice. *Law and Human Behavior*, 34, 259-274.
- Ellerby, L., McGrath, R. J., Cumming, G. F., Burchard, B. L., Zeoli, S. (2010). *Current practices in Canadian sexual abuser treatment programs: The Safer Society 2009 Survey*. Brandon, Vermont: Safer Society Press.
- Elkovitch, N., Viljoen, J. L., Scalora, M. J., Ullman, D. (2008). Assessing risk of reoffending in adolescents who have committed a sexual offense: The accuracy of clinical judgments after completion of risk assessment instruments. *Behavioral Sciences and Law*, 26, 511-528.

- Epperson, D. L., Ralston, C. A., Fowers, D., & DeWitt, J. (2006). Juvenile Sexual Offense recidivism Risk Assessment Tool-II (JSORRAT-II). In D. S. Prescott (Ed.), *Risk assessment of youth who have sexually abused* (pp. 222-236). Oklahoma City, OK: Wood N' Barnes.
- Fago, D. P. (2003). Evaluation and treatment of neurodevelopmental deficits in sexually aggressive children and adolescents. *Professional Psychology: Research and Practice*, 34(3), 248-257.
- Gunby, C., & Woodhams, J. (2010). Sexually deviant juveniles: Comparisons between the offender and offence characteristics of 'child abusers' and 'peer abusers.' *Psychology, Crime, & Law*, 16, 47-64.
- Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, 66(2), 348-362.
- Hanson, R. K., Morton-Bourgon, K. E. (2004). *Predictors of sexual recidivism: An updated meta-analysis*. Ottawa: Public Safety and Emergency Preparedness Canada.
- Hanson, R. K., Morton-Bourgon, K. E. (2009). The accuracy of recidivism risk assessments for sexual offenders: A meta-analysis of 118 prediction studies. *Psychological Assessment*, 21(1), 1-21.
- Hanson, R. K., Howard, P. D. (2010). Individual confidence intervals do not inform decision-makers about the accuracy of risk assessment evaluations. *Law and Human Behavior*, 34, 275-281.
- Hunter, J. A., Figueredo, A. J., Malamuth, N. M., & Becker, J. V. (2003). Juvenile sex offenders: Toward the development of a typology, *Sexual Abuse: A Journal of Research and Treatment*, 15, 27 to 48.
- Hunter, J. A., Hazelwood, R. R., & Slesinger, D. (2000). Juvenile sexual homicide. *FBI Law Enforcement Bulletin*, 69(3), 1-7.
- Kemper, T. S., Kistner, J. A. (2007). Offense history and recidivism in three victim-age-based groups of juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 19, 409-424.
- Kimonis, E. R., Fanniff, A., Borum, R., Elliott, K. (2011). Clinician's perceptions of indicators of amenability to sex offender-specific treatment in juveniles. *Sexual Abuse: A Journal of Research and Treatment*, 23, 193-211.
- Kraemer, B. D., Salisbury, S. B., Spielman, C. R. (1998). Pretreatment variables associated with treatment failure in a residential juvenile sex-offender program. *Criminal Justice and Behavior*, 25, 190-202.

- Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., Chapman, J. E., Saldana, L. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology*, 23(1), 89-102.
- Letourneau, E. J., Bandyopadhyay, D., Armstrong, K.S., & Sinha, D. (2010). Do sex offender registration and notification requirements deter juvenile sex crimes? *Criminal Justice and Behavior*, 37, 553-569.
- Letourneau, E. J., & Miner, M. H. (2005). Juvenile sex offenders: A case against the legal and clinical status quo. *Sexual Abuse: A Journal of Research and Treatment*, 17, 313-331.
- McGrath, R., Cumming, G., Burchard, B., Zeoli, S., & Ellerby, L. (2010) *Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey*. Brandon, Vermont: Safer Society Press.
- Miccio-Fonseca, L. C. (2009). MEGA: A new paradigm in protocol assessing sexually abusive children and adolescents. *Journal of Child and Adolescent Trauma*, 2, 124-141.
- Marshall, W. L., & Barbaree, H. E. (1990). An integrated theory of the etiology of sexual offending. In W. L. Marshall, D. R. Laws & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories and treatment of the offender* (pp. 257-275). New York: Plenum.
- Nguyen, Q., Pittman, N. (2011). *A snapshot of juvenile sex offender registration and notification laws: A survey of the United States*. Retrieved January 25th, 2012, from http://www.njjn.org/uploads/digital_library/SNAPSHOT_web10-28.pdf
- Nisbet, I. A., Wilson, P. H., Smallbone, S.W. (2004). A prospective longitudinal study of sexual recidivism among adolescent sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 16(3), 223-234.
- Office of Juvenile Justice and Delinquency Prevention (2011). *National Report Series Bulletin: Juvenile arrests 2009*. Washington, DC: U.S. Department of Justice.
- Olver, M. E., Stockdale, K. C., Wormith, J. S., (2009). Risk assessment with young offenders: A meta-analysis of three assessment measures. *Criminal Justice and Behavior*, 36, 329-353.
- Parks, G. A., Bard, D. E. (2006). Risk factors for adolescent sex offender recidivism: Evaluation of predictive factors and comparison of three groups based upon victim type. *Sex Abuse*, 18, 319-342.
- Prentky, R., & Righthand, S. (2003). *Juvenile Sex Offender Assessment Protocol-II (J-SOAPII) manual* (NCJ Publication No. 202316). Washington, DC: Office of Juvenile Justice and Delinquency Prevention. Retrieved from <http://www.csom.org/pubs/JSOAP.pdf>

- Prescott, D., & Longo (2006). Introduction. In R. E. Long & D. S. Prescott (Eds.), *Current perspectives: Working with sexually aggressive youth & youth with sexual behavior problems* (pp. 45-62). Holyoke, MA: NEARI Press.
- Reitzel, L. R., & Carbonell (2006). The effectiveness of sexual offender treatment for juveniles as measured by recidivism: A meta-analysis. *Sex Abuse, 18*, 401-421.
- Richardson, G., Kelly, T. P., Bhate, S. R., Graham, F. (1997). Group differences in abuser and abuse characteristics in a British sample of sexually abusive adolescents. *Sexual Abuse: A Journal of Research and Treatment, 9*, 239-257.
- Righthand, S. and Welch, C. (2001). Juveniles Who Have Sexually Offended: A Review of the Professional Literature. *Office of Juvenile Justice and Delinquency Prevention*.
- Ryan, G., Leversee, T., Lane, S. (2010). Juvenile sexual offending: Causes, consequences, and correction (3rd ed.). Hoboken, NJ: John Wiley and Sons Inc.
- Seto, M.C. & Lalumiere, M. L. (2010). What is so special about male adolescent sexual offending? A review and test of explanations through meta-analysis. *Psychological Bulletin, 136*(4), 526-575.
- Sreenivasan, S., Weinberger, L. E., Frances, A., Cusworth-Walker, S. (2010). Alice in actuarial-land: Through the looking glass of changing Static-99 norms. *The Journal of the American Academy of Psychiatry and the Law, 38*, 400-406.
- Stinson, J. D., Sales, B. D., Becker, J. V. (2008). *Sex offending: Causal theories to inform research, prevention, and treatment*. Washington DC: American Psychological Association
- van Wijk, A. Ph., Mali, S. R. F., Bullens, R. A. R. (2007). Juvenile sex-only and sex-plus offenders: An exploratory study on criminal profiles. *International Journal of Offender Therapy and Comparative Criminology, 51*, 407-419.
- Viljoen, J. L., Elkovitch, N., Scalora, M. J., Ullman, D. (2009). Assessment of re-offense risk in adolescents who have committed sexual offenses: Predictive validity of the ERASOR, PCL:YV, YLS/CMI, and Static-99. *Criminal Justice and Behavior, 36*, 981-1000.
- Viljoen, J. L., Mordell, S., & Beneteau, J. L. (2012). Prediction of adolescent sexual reoffending: A meta-analysis of the J-SOAP-II, ERASOR, J-SORRAT-II, and Static-99. *Law And Human Behavior*, doi:10.1037/h0093938.
- Vincent, G. M., Chapman, J., Cook, N. E. (2011). Risk-needs assessment in juvenile justice: Predictive validity of the SAVRY, racial differences, and the contribution of needs factors. *Criminal Justice and Behavior, 38*, 42-62.

- Vitacco, M. J., Viljoen, J., Petrila, J. (2009). Introduction to this issue: Adolescent sexual offending. *Behavioral Sciences and Law*, 27, 857-861.
- Worling, J. R. (2001). Personality-based typology of adolescent male sexual offenders: Difference in recidivism rates, victim-selection characteristics, and personal victimization histories. *Sexual Abuse: A Journal of Research and Treatment*, 13(3), 149-166.
- Worling, J. R., & Curwen, T. (2000). Adolescent sexual offender recidivism: Success of specialized treatment and implications for risk prediction. *Child Abuse and Neglect*, 24(1), 965-982.
- Worling, J. R., & Curwen, T. (2001). Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Version 2.0). In M. C. Calder (Ed.), *Juveniles and children who sexually abuse: Frameworks for assessment* (pp. 372-397). Lyme Regis, UK: Russell House.
- Worling, J. R., Bookalam, D., & Litteljohn (2011). Prospective validity of the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR). *Sexual Abuse: A Journal of Research and Treatment*, 1079063211407080
- Worling, J. R., Litteljohn, A., & Bookalam, D. (2010). 20-year prospective follow-up study of specialized treatment for adolescents who offended sexually. *Behavioral Sciences and the Law*, 28, 46-57. doi:10.1002/bsl.912

An Online Survey of JSO Practice Characteristics and Methods (rev. 10-8-12)

Introduction

The CCOSO Research Committee collaborated with the Adolescent Practices and Guidelines Committee to conduct an online survey of providers who treat male juveniles who sexually offend (JSO). The survey was conducted to provide information about current practices as a basis for the development of guidelines for adolescent JSO practice. The responses were anonymous and individual programs were not identified. No attempt was made to identify whether there was more than one response from individual programs. 31 respondents completed the entire questionnaire. Responses are in the tables in Appendix 1.

Cross tabulations were conducted by program settings, residential (N=12) versus outpatient (N=18). Outpatient programs included solo practice, group practice, nonprofit programs, or government based programs. Residential programs also included secure settings such as juvenile halls, County ranch programs, or Department of Juvenile Justice (DJJ). A total of 30 individuals produced responses that could be classified in this way. One respondent reported both outpatient and residential treatment settings and could not be used for this analysis. The cross tabulation was done to see if there might be differences in practices between the two settings. Only a limited number of variables were examined. The cross tabulation results are noted in the relevant sections. Significant testing using a two-tailed Fisher's exact test was done on all cross tabulations, and only results that were significant ($P<.05$) were noted.

Program and Provider Characteristics

Program and provider characteristics were surveyed. Table 1 shows that 45.2% were in outpatient individual practice, with 16.1% in outpatient group practice, 16.1% in outpatient not for profit programs, and 6.5% in County or other government agency. 32.3% were in residential settings, 9.7% in juvenile hall or other secure settings, and 3.2% in DJJ.

Table 2 shows that about half the responders were program administrators and 83.9% were licensed mental health clinicians. Table 3 reports on the age of program participants. On average, 22% of program participants were ages 11 to 14, and the rest ages 15 to 18. Over 90% reported doing individual therapy with youth, about two thirds also did group therapy with youth, 54.8% conducted therapy with parents or guardians individually, and 19.4% used groups with parents. 77.4% reported doing family therapy (Table 4).

A cross tabulation by program type regarding treatment services showed the following:

<u>Treatment services</u>	Residential%	Outpatient %
Individual youth treatment	100	89
Group youth treatment	75	61
Therapy with family individually	58	50
Therapy with family in group	8	28
Family therapy with family and youth	92	75

As can be seen, practices are similar in the two settings, except family group therapy is more common with outpatient, and likewise family therapy with the family and youth is more common in residential settings. Also, a hundred percent of residential programs had individual treatment. While 81% of outpatient programs used individual treatment, those that did not, all used group treatment.

Treatment Methods

Treatment methods were also reviewed. Table 5 indicated that 96.8% of respondents identified using cognitive behavioral therapy and 64.5% used relapse prevention methods. Pathways by Timothy Kahn (Safer Society Press) was used by 41.9% of respondents.

Regarding evidence based treatment (EBT) approaches for delinquency prevention, Aggression Replacement Training is the most frequent method used, with 32.3% of respondents. The next most frequently used EBT model was Multisystemic Therapy with 22.6%.

Table 6 reviewed specific techniques used, separate from general treatment models. Approaches used greater than 80% included anger management, assertiveness training, cognitive restructuring, empathy training, full disclosure in individual therapy, personal trauma victimization, self-esteem, sexual offense cycles, social and interpersonal skills training, and stress management techniques. Over 90% reported education about laws regarding sex and healthy sexual behaviors.

A cross tabulation was done comparing residential with outpatient settings regarding evidence-based treatments for delinquent behaviors. Results are noted below:

<u>Evidence-based methods for delinquency</u>	Residential%	Outpatient %
Aggression Replacement Training	42	28
Dialectical Behavior Therapy	25	6
Multisystemic Therapy	25	17
Thinking for a Change	25	11
Functional Family Therapy	8	6

Rates of use of these methods do not appear to differ widely between residential and outpatient settings.

Assessment Methods for Sexual Recidivism

Rates of use for assessment methods for sexual recidivism are shown in Table 7. Two thirds of respondents used the JSORRAT-II. 29.0% used the JSOAP-II, 22.6% used the ERASOR-2, and 22.6% used the MEGA. 22.6% were not using any of the risk assessment instruments listed.

In Table 8 respondents indicated various assessment information available before or shortly after admission. Results were as follows: DSM-IV diagnoses 74.2%, cognitive and intelligence assessment 45.2%, educational assessments 29.0%, and assessment of sexual interests 45.2%. 22.6% had none of these assessment data available.

Cross tabulation of the use of tools for assessing the risk of sexual recidivism by residential versus outpatient programs is as follows:

<u>Sexual recidivism risk tools</u>	Residential%	Outpatient %
JSORRAT-II	67	71
JSOAP-II	33	29
ERASOR-2	33	17
MEGA	42	11
None of the above	25	22

Rates of use of the JSORRAT-II and the JSOAP-II do not vary notably between settings, but the ERASOR-2 and the MEGA are used more often in residential settings.

The cross tabulation by program setting for psychiatric and psychoeducational assessment information is as follows:

<u>Psychiatric and psychoeducational assessments</u>	Residential%	Outpatient %
Psychiatric diagnosis using DSM-IV	92	67
Educational achievement testing	67*	6
Cognitive testing	67	33
DSM-IV diagnosis, educational, and cognitive testing	58#	6
Psychiatric symptom rating scales	33	6
Sexual interest ratings	42	50
None of the above	8	28
*P<.001, #P=.003, using two-tailed Fisher's Exact Test		

Regarding assessment methods, residential programs have more assessment information, particularly regarding educational achievement and cognitive testing. 58% of residential programs had psychiatric, academic, and cognitive testing, that is all three types of information, compared to 6% of outpatient programs.

Evidence Based Methods

The use of evidence based methods was assessed. 83.9% reported using such methods. All those not using such methods would, if these methods were practical and affordable (Tables 9 & 10). 74.2% indicated they measured treatment outcomes in their program. 45.2% used published or standardize curriculum in their program, and 61.3% use curriculum they develop themselves (Table 11).

The cross tabulation for residential versus outpatient for evidence based methods and type of curriculum is as follows:

<u>Evidence based methods</u>	Residential%	Outpatient %
Evidence-based treatment methods use	92	75
Treatment outcomes measured	75	38
Published curriculum used	33	63
Developed own curriculum	67	69

Residential programs were more likely to measure treatment outcomes and less likely to use published curriculum, but both treatment settings were about equally likely to develop their own curriculum materials.

Appendix 1: Tables

Table 1. Is your program...

	Response Percent	Response Count
Outpatient Individual Practice	45.2%	14
Outpatient Group Practice	16.1%	5
Outpatient Program- part of for-profit or nonprofit agency	16.1%	5
Outpatient Program- County or other government agency	6.5%	2
Residential Group Home	32.3%	10
Juvenile Hall or other secure setting (e.g., County Ranch)	9.7%	3
Department of Juvenile Justice (DJJ)	3.2%	1
Other		2

Table 2. Is your role in the program...

	Response Percent	Response Count
Program administrator	51.6%	16
Licensed mental health clinician	83.9%	26
License eligible mental health clinician	0.0%	0
Other counseling staff	0.0%	0
Residential counselor	0.0%	0
Other role	3.2%	1

Table 3. What percent of your juvenile clients ages 11-18 are... (must total to 100%)

	Response Average	Response Count
11-14	22%	31
15-18	78%	31

Table 4. What therapy modalities does your program routinely use?

	Response Percent	Response Count
Individual therapy with youth	93.5%	29
Group therapy with youth	67.7%	21
Therapy with parents or guardians individually	54.8%	17
Therapy with parents or guardians in groups	19.4%	6
Family therapy with youth and parent/guardian	77.4%	24
Other		2

Table 5. What therapy models or programs do you use?

	Response Percent	Response Count
Aggression Replacement Training (ART)*	32.3%	10
Cognitive Behavioral Therapy (CBT)	96.8%	30
Dialectical Behavior Therapy (DBT)*	12.9%	4
Functional Family Therapy (FFT)*	9.7%	3
Incredible Years	0.0%	0
Multisystemic Therapy (MST)*	22.6%	7
Narrative Therapy	3.2%	1
Pathways by Kahn	41.9%	13
Relapse prevention	64.5%	20
Roadmaps by Kahn	12.9%	4
Seeking Safety**	12.9%	4
Thinking for a Change*	16.1%	5
Trauma Focused CBT**	16.1%	5
None of the above	0.0%	0
Other		3

*- Evidence based methods for reducing delinquency.

** - Evidenced based methods for treating trauma.

Table 6. What treatment techniques do you use?

	Response Percent	Response Count
Anger management	83.9%	26
Assertiveness training	83.9%	26
Biofeedback	12.9%	4
Cognitive restructuring	83.9%	26
Community reentry/living skills	64.5%	20
Education about laws regarding sexual behaviors and/or legal issues and procedures	90.3%	28
Education leading to a High School diploma or equivalent	38.7%	12
Empathy training	87.1%	27
Family of origin work	54.8%	17
Full disclosure of sexual offense in group therapy	51.6%	16
Full disclosure of sexual offense in individual therapy	83.9%	26
Group therapy	64.5%	20
Individual therapy	93.5%	29
Journal use	41.9%	13
Maintenance behaviors	58.1%	18
Moral reasoning/values formation	64.5%	20
Neurofeedback	3.2%	1
Parent/guardian collateral meetings/therapy	67.7%	21
Personal trauma and victimization	80.6%	25
Polygraph	19.4%	6
Prevocational/vocational	25.8%	8

Safety plan	74.2%	23
Self esteem	83.9%	26
Sexual offense cycles	83.9%	26
Sex education and healthy sexual behaviors	90.3%	28
Social and interpersonal skills training	87.1%	27
Stress management techniques	80.6%	25
None of the above	0.0%	0
Other		1

Table 7. What assessment instruments do you use?

	Response Percent	Response Count
JSORRAT-II	67.7%	21
JSOAP-II	29.0%	9
ERASOR-2	22.6%	7
MEGA	22.6%	7
YOQ	6.5%	2
LS/CMI	19.4%	6
None of the above	22.6%	7
Don't know	0.0%	0
Other		4

Table 8. Which of the following assessments do you have available before or shortly after admission to your program?

	Response Percent	Response Count
Psychiatric diagnosis using DSM-IV	74.2%	23
Assessment of educational achievement using standardized Tests (WRAT-IV, WJ 3, WIAT-III, etc.)	29.0%	9
Assessment of cognitive and intelligence areas	45.2%	14
Assessment of psychiatric symptoms using rating scale (MAPI, SCL90-R, YOQ, etc.)	16.1%	5
Assessment of sexual interests	45.2%	14
None of the above	22.6%	7
Other		3

Table 9. We use evidence based treatment methods in our program.

	Response Percent	Response Count
Yes	83.9%	26
Not sure	12.9%	4
No	3.2%	1

Table 10. We would be interested in using evidence based methods if they were practical to use and affordable.

	Response Percent	Response Count
Yes	100.0%	5
No	0.0%	0
Other/Uncertain	0.0%	0

Table 11. Please answer the following regarding your program.

	Response Percent	Response Count
We measure treatment outcomes in our program in some way	74.2%	23
We use standardized or published curriculum materials like Pathways or Roadmaps	45.2%	14
We use curriculum materials we developed ourselves	61.3%	19
Other		1