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Evaluation of Juvenile Sex Offenders

Introduction

Scope of problem

Juvenile sex offending is a significant social problem, the scope of which may well be underestimated due to the underreported nature of sex offending.[1] Some estimates indicate that close to 20 percent of forcible rapes are committed by juveniles under the age of 18 years.[2] In many jurisdictions, New Jersey for example, juveniles are treated little differently than adults with regard to community notification. Juvenile sex offending treatment programs—both inpatient and outpatient—are springing up around the country.

What do we know about assessing and treating juvenile sex offenders? How can sex offending teens be helped? With what frequency do they commit new sex offenses? What methods can be used to assess risk to the community? Is treatment

effective? Are juvenile sex offenders different from other troubled teens? From adult sex offenders? These questions vex both professional and layperson alike.

Causes/characteristics of juvenile sex offending

Juvenile sex offending can be viewed as the end of a path, or trajectory, that leads a teenager to commit such an act. There are a few possible trajectories discussed in the literature. A number of authorities[3] have proposed taxonomies for juvenile sex offenders, and these taxonomies share common characteristics that can guide our understanding of the possible paths that can lead to sex offending. For example, one of the earliest typologies (dating from 1986) of adolescent sex offenders was proposed by O'Brien and Bera:[4]

1. Naive experimenters
2. Undersocialized child exploiters
3. Sexual aggressives
4. Sexual compulsives
5. Disturbed impulsives
6. Group influenced
7. Pseudosocialized

Although this taxonomy has intuitive appeal and face validity, there has been no empirical investigation of its reliability or validity.[5] The most current taxonomy of juvenile sex offenders, one that includes the broad factors found in the literature, is the result of cluster analysis of psychological testing results discussed by Worling:[6]

a. Antisocial/Impulsive: These juvenile sex offenders share many characteristics with their cohort that is committing non-sexual offenses. Poor academic performance, aggressive, coercive acts towards others, family disruption, and association with antisocial peers are common among this group. It is common to find histories of physical or emotional abuse among this group. Early initiation of substance use and abuse is frequent. Sex offenses, for delinquents, are simply one more means of behaving coercively and exploitively. Offenses tend to be more violent and against older victims. This group experiences high levels of psychopathology, primarily externalizing behavior problems, as well as higher rates of recidivism, sexual and otherwise. This is the largest group of juvenile sex offenders. They may offend because of a generally exploitive, coercive, impulsive orientation towards others.
b. Unusual/Isolated: These juvenile sex offenders are characterized as strange, interpersonally distant and isolated, and confused. They have high levels of psychopathology, in their case, internalizing behavior problems. Like the Antisocial/Impulsive group, these offenders have high recidivism rates relative to the final two groups. They have difficulty forming healthy age-appropriate intimate relationships. They may offend because of severe interpersonal and cognitive deficits.
c. Overcontrolled/Reserved: This group shows lower levels of psychopathology than the previous two groups. They do not share the delinquent inclinations of the Antisocial/Impulsive group or the peculiar,

bizarre behavior and ideation of the Unusual/Isolated group. They endorse prosocial attitudes, but tend to avoid expressions of emotion. They may offend as a result of shyness with age-peers. Recidivism levels are relatively low for this group.

d. Confident/Aggressive: This group shows lower levels of psychopathology than the first two groups. They are characterized as friendly, confident, and outgoing, although somewhat narcissistic. Their offenses result from a self-centered orientation lacking in empathy. They show relatively low recidivism rates, relative to the first two offender groups.

The antisocial/impulsive group described above conforms relatively closely to that group of juveniles with general delinquency problems. Members of this group with the most extreme form of this disorder begin displaying noncompliant, coercive, aggressive behaviors in childhood and gradually escalate the severity and frequency of such behaviors through their adolescent years. Such teenagers are referred to as early starters or life course delinquency adolescents,[7] and the risk they present is considerable (although perhaps as much for nonsexual offenses as for sexual offenses), and treatment plans must focus heavily on general delinquency issues.

One theme that Worling and Curwen's four way taxonomy system does not capture is the extent of deviant sexual interest. An individual in any of the four groups could display deviant sexual interest and arousal, and the extent of such deviant sexual interest increases the extent of the risk he presents for future sex offending.[8]

Risk assessment

Principles

When youth are identified as having problems with abusive and/or criminal sexual behavior, typically either through arrest or a child protection agency investigation, risk assessment begins immediately. Risk assessment affects:

1. the intensity of supervision if the juvenile remains in the community,
2. the extent of treatment interventions,
3. the likelihood of future offenses, which in turn may determine the level of community notification, and
4. the level of security the juvenile requires, which could vary from retention in the family home to placement in a therapeutic foster home to inpatient/residential treatment to a secure criminal justice facility.

Risk assessment occurs at a fixed point, such as at arrest or at release from incarceration. Risk assessment involves heavy emphasis on static, historical factors, such as number of victims or history of antisocial behavior.[9] In juvenile risk assessment for violent crimes generally, risk assessment has become less impressionistic and more structured and empirically guided in recent decades,[10] and risk assessment of juvenile sex offenders has followed this trend. Most of us would like to think that we are good judges of character and can tell when a person before us is dangerous or not. However, given that recent research indicates that clinicians make accurate judgments in this area at a rate slightly better than chance when using unstructured clinical judgment,[11] the development of structured, empirically based risk assessment methods has been a welcome development.

Some authorities contrast risk assessment with risk management. Risk management refers to the ongoing process of assessing changes in an offender's immediate risk and devising methods for lowering that risk. Heilbrun, perhaps the originator of this distinction, suggests that we view risk assessment as involving a single assessment with heavy emphasis on static risk factors where the goal is to determine the likelihood of a future offense.[12] Heilbrun, Cottle and Lee[13] note that the evaluator needs to determine if the referral question in an evaluation is to make a prediction of future violence or to determine the best way to manage risk. As Hanson notes, far more is known about risk assessment than about risk management:

> We know a lot about how offense history variables are associated with the recidivism of sexual offenders. By examining static, historical factors such as age, prior convictions, and the gender and relationship to the victims, we can reliably identify groups of sexual offenders who are at substantial risk for sexual recidivism. We know much less about how to reduce risk.[14]

Most often the referral question is simply: Is this juvenile sex offender going to commit another sex offense? This question can only be addressed by clinicians aware of the current research in the field.[15]

Risk factors are generally divided into two classes:[16]

Static: Historical factors not subject to change, such as

- Number of prior sexual offenses
- Characteristics of prior sexual offenses
- Prior victim selection
- Prior nonsexual antisocial behavior

- Sexual history
- Family history
- Past psychiatric history

Dynamic: Factors subject to change over time, either slowly (stable dynamic factors) or rapidly (acute dynamic factors), such as

- Motivation
- Acceptance of responsibility
- Level of victim empathy
- Quality of peer relationships
- Level of sexual self regulation
- Level of general self regulation
- Current substance abuse
- Current symptoms of mental illness

Static factors have been studied the longest, in part because these are easiest to obtain from archival data. The dynamic factors are complex, difficult to measure constructs that frequently require a clinical interview. Therefore, dynamic factors are more expensive to obtain and have associated problems of interrater reliability. It is only in the past few years that research has progressed regarding dynamic risk factors.[17]

The lay public frequently views juvenile sex offenders (and adult sex offenders alike) as having close to 100% recidivism rates. The reality is quite different. With regard to adult sex offenders, the base rate is far lower. Perhaps the most comprehensive

meta-analysis, conducted by Hanson and Bussiere, found adult sex offender recidivism to be roughly 15% over a large number of pooled follow-up studies.[18] Another recent meta-analysis, which pooled studies to assess the effectiveness of treatment on adult sex offenders, found a sexual recidivism rate of about 12% for treated sex offenders and 17% sexual recidivism rate for untreated sex offenders, again, far below the intuitive estimates of the general public.[19]

Relatively few studies have assessed juvenile sex offender recidivism. One study, a short-term follow-up of one year, found 3% sexual recidivism.[20] A recent review by the Juvenile Sex Offender Focus Group[21] found adolescent sexual recidivism rates between 2% to 19%. One of the higher juvenile recidivism rates was published by Swedish researchers who found that 20% of their sample sexually reoffended at a 5 year mean follow-up period.[22] What most researchers note, with adult as well as adolescent sexual offenders, is much higher rates of non-sexual recidivism, that is, non-sexual criminal behavior that results in further criminal justice attention. Hanson and Bussiere[23] found a 40% non-sexual recidivism rate among adults, while the Swedish study of juveniles found that 65% recidivated non-sexually.[24] As is clear from above, it is essential to define recidivism. In the literature, recidivism has been variously defined as further sexual offending behavior, criminal charges or adjudications for other criminal activity, or sometimes even non-compliance with supervision conditions.

Factor analysis of the risk factors shown to predict adult sexual and non-sexual recidivism indicates that there are two major domains of concern: deviant sexual interest and general criminality. Not surprisingly, deviant sexual interest is a better predictor of sex offending recidivism, and general criminality is a better predictor of non-sexual

recidivism in adults.[25] Although there is disagreement about the applicability of research on adult sex offenders to adolescents who engage in similar behaviors, there is much to be gained in examining these findings.

With juveniles, as with adults, there are different risk factors for sexual versus other criminal recidivism. Langstrom and Grann[26] report that previous criminality, early onset conduct disorder, psychopathy and use of threats or weapons in the index crime predict non-sexual recidivism, while early onset of sexually abusive behavior, more than one victim, male victim choice, and poor social skills were associated with sexual recidivism. Worling and Curwen[27] reached similar findings: different risk factors explained sexual and non-sexual recidivism. Whereas sexual interest in children predicted sexual reoffense, general criminal factors predicted non-sexual recidivism. This bifurcation of sexual versus non-sexual risk factors speaks to the need for individualized treatment that addresses a variety of needs.

Various authors have classified risk assessment methods in terms of the amount of structure involved in and the amount of empirical support for the procedure.[28] Hanson describes a continuum of risk assessment procedures:[29]

1. Unstructured clinical
    - Clinician determines what questions to ask and what constructs to measure
    - Flexible administration
    - Potentially multiple data sources
    - Heavy reliance on clinical interview
    - Intuitive, idiosyncratic algorithm for determining risk

- No validation or reliability data

2. Structured clinical
    - Consistent list of risk factors assessed
    - Guided by clinician's intuitive understanding of what characteristics are associated with risk
    - Reliable administration, since based on consistent risk factor list
    - No validation or reliability data
    - Potentially multiple sources of data
3. Empirically guided clinical
    - Consistent list of risk factors assessed
    - Risk factors based on review of empirical literature
    - Informed by professional literature
    - Consistent, reliable process
    - Uniform method for determining risk level
    - Potentially multiple sources of data
    - May or may not have concurrent and predictive validity studies
4. Actuarial
    - Consistent list of risk factors assessed
    - Risk factors based on review of empirical literature
    - Informed by professional literature
    - Specific mathematical algorithm for determining a risk score

- Limited to risk factors found to be related to recidivism in standardization study

5. Clinically adjusted actuarial
    - Administration of multiple actuarial instruments
    - Results integrated into composite risk assessment through consideration of the properties of the individual instrument

Historically, the field has moved from the unstructured, non-empirical side of the continuum toward the structured, empirically based side of the continuum. Perhaps ten years ago, almost all risk assessment reports would have been based on an unstructured clinical interview and review of the file. The particular risk factors were implicit, intuitive, and usually not articulated specifically. Next, evaluators began relying on risk assessment checklists, typically developed by individual clinician based on his or her personal experience. In the mid to late 90's, empirically guided and actuarial instruments were developed, and most risk assessment specialists rely on such instruments today.

Tools[30]

There has been considerable progress in the development of empirically guided or actuarially-based adult sexual offense risk assessment instruments.[31] At present, this progress informs our work with adolescents, but does not provide any easy answers. Why is that the case?

Adolescence is a time of developmental flux. For that reason, an assessment of current risk may lose its predictive validity over time. Adolescents are also more affected than adults by contextual forces. Parents and peers affect adolescents' thoughts and

behaviors. Although these forces are concerns in assessing adult sexual offenders, they appear more immediate and salient with adolescents.

Despite these caveats, there are now useful tools to help in the assessment process. A family resemblance among the instruments is evident, as all assess some combination and weighting of similar risk factors. While there have been many juvenile sex offender risk assessment checklists,[32] until recently, none had been empirically validated.

Probably the best known juvenile sexual recidivism instrument, and one of two such instruments with any empirical validity studies, is the Juvenile Sex Offender Assessment Protocol (J-SOAP),[33] developed by Robert Prentky and associates. Prentky et al. acknowledge that the J-SOAP is hampered by a small sample size, short follow up, and low recidivism base rate, but research continues on this instrument, which represents an excellent starting point. The J-SOAP assesses four factors:

1. Sexual drive/preoccupation
2. Impulsive/antisocial behavior
3. Clinical/intervention
4. Community stability/adjustment

The Estimate of Risk of Adolescent Sex Offense Recidivism (ERASOR),[34] is the second instrument with any validation studies, even if preliminary. The ERASOR is an empirically guided scale in that the authors, Worling and Curwen, surveyed the empirical literature and selected 25 criteria grouped into five broad domains supported as risk factors in the empirical literature. These domains are:

1. Sexual interests, attitudes, and behavior
2. Historical sexual assaults
3. Psychosocial functioning
4. Family/environmental functioning
5. Treatment

In a comprehensive manual, the authors provide a rationale and empirical support for each of the 25 criteria. The manual itself is a useful, well-organized review of the adolescent sexual offending risk assessment literature.

The Juvenile (Clinical) Risk Assessment Tool of Risk for Sexual Re-Offending (J-RAT), and the Interim Modified Risk Assessment Tool for Sexual Re-Offending Response to Treatment (IM-RAT)[35] is a wide-ranging assessment package that incorporates both an initial assessment of risk (the J-RAT) and a method of ongoing re-evaluation of progress in treatment and risk of reoffense (the IM-RAT). This tool, designed for a residential treatment center for adolescents, provides evaluators with a structured, guided clinical approach to adolescent sex offender risk assessment. While an excellent example of a structured clinical tool, the J-RAT does not yet have research on its validity. The J-RAT considers 12 factors, or risk domains[36] as the author, Rich, describes them, many of which require a clinical interview and clinical judgment:

1. Responsibility
2. Relationships
3. Cognitive ability
4. Social skills
5. Past trauma

6. Personal characteristics and qualities
7. Co-morbidity and past treatment response
8. Substance abuse
9. Antisocial behaviors
10. Pattern of sexual offending behavior
11. Family factors
12. Environmental conditions

One study of adolescents, all 18 years old but having entered the system as juveniles, by the Texas Youth Authority compared scores on the STATIC-99[37]—a widely used adult sexual offender recidivism scale that assesses static risk factors such as prior sex offenses, prior non-sexual violence, and victim characteristics—with rates of sexual offense recidivism.[38] By using a cut score of 6 points (out of a total possible 12 points) these researchers accurately identified the juvenile sexual recidivists in their sample. These results suggest that many of the static, historical risk factors useful in predicting sexual offending recidivism with adults are equally useful in evaluating juveniles.

Assessing the risk juvenile sex offenders pose might be best addressed by a risk assessment that considers sexual offending-specific risk factors separately from general violence risk factors. Aside from the sexual offense risk assessment instruments mentioned above, there are other assessment instruments that could serve the purpose of establishing a risk level for non-sexual reoffending. One recent example of an empirically guided structured instrument for assessing non-sexual violent juvenile recidivism is the Structured Assessment of Violence Risk in Youth (SAVRY)[39] The SAVRY systematically samples both static and dynamic risk factors statistically

associated with violent recidivism in juveniles. The SAVRY divides these risk factors into three classes:

1. Historical risk factors (such as history of violence, early initiation of violence, past supervision/intervention failures, and poor school achievement)
2. Social/contextual risk factors (such as peer delinquency, peer rejection, poor parental management, and lack of personal/social support)
3. Individual/Clinical risk factors (such as substance use difficulties, anger management problems, psychopathic characteristics, and low commitment to school)

The SAVRY has the unusual feature of assessing protective factors as well. It is generally accepted be that although two juveniles may have the same risk factors, one may show significantly less likelihood of reoffending if that juvenile has protective factors.[40] Protective factors include prosocial involvement, strong social support, strong attachments and bonds (to positive figures), and a strong commitment to school. The SAVRY manual reports two validity studies of the SAVRY, both of which support its positive relationship with future serious delinquent acts.[41]

Physiological assessment methods

Interviewing sex offenders, juvenile or otherwise, regarding the extent to their illegal sexual behavior or deviant sexual interests presents obvious problems: sex offenders tend to minimize the amount and degree of such sexual deviance. Their self reports are frequently considered unreliable. Understandable feelings of shame, in addition to perhaps realistic fear regarding the potential consequences of further

revelations of deviant sexual behavior or interest, motivate sex offenders to deny the existence of illegal sexual behavior and interest. Consequently, in an attempt to obtain a more objective measure of such illegal behavior and interest, evaluators sometimes use physiologic assessment methods. These methods can be particularly useful in assessing the effectiveness of treatment procedures, such as covert sensitization or masturbatory satiation, that target deviant sexual urges or in ensuring compliance with treatment and supervisory requirements. Three physiologic assessment methods are commonly used:

Polygraph

The polygraph—in which the measurement of changes in heart rate, blood pressure, sweat production, and respiration are measured in response to verbal stimuli regarding offense-related behavior—is increasingly being used to confirm self-reported treatment gains, such as not masturbating to deviant fantasies and a decrease in sexually deviant urges. Historically, polygraph evaluations have been common in police settings, but uncommon in clinical settings. As Quinsey and Lalumiere note, "The validity of polygraphy has been the center of controversy since its first use at the beginning of this century, and more specifically in the last 30 years...."[42] The major concern is the relatively high error rate, particularly for false positives.[43] Some studies, in fact, have found little more than chance accuracy.[44] Given the general belief of the lay public that polygraph examinations can detect lies, however, sex offenders, adolescents and otherwise, disclose more information regarding the number and type of victims, use of force, and use of pornography when undergoing polygraph testing.[45] Consequently, the most common use of polygraph testing is in ongoing monitoring of sex offenders, given

that sex offenders tend to report more deviance when taking a polygraph examination than otherwise, suggesting that the sex offenders are being more honest.[46]

Plethysmograph

In an attempt to avoid relying on a sex offender's potentially false self-report regarding his sexual interests, some clinicians use a penile plethysmograph to assess deviant sexual arousal. This device measures penile circumference changes in the presence of sexually deviant stimuli, most commonly audio stimuli. This assessment is no longer as widely used as was once the case due to ethical and legal concerns resulting from the intrusiveness of the procedure. Of all the physiologic methods used to assess deviant sexual interest, penile plethysmography is generally considered the gold standard.[47] However, the presence of sexual arousal, either normal or deviant, is easier to interpret that its absence. In other words, although the sensitivity of plethysmography is only moderate, its specificity is high.[48] Plethysmography has been used primarily with adults, not juveniles.[49]

Viewing Time

Because of concerns regarding the intrusiveness of penile plethysmography, some evaluators have been covertly measuring viewing time. As described by Quinsey Lalumiere:[50]

> Typically, clients are asked to perform a task with visual stimuli, and the time that they spend viewing each stimulus is unobtrusively recorded. It is essential that clients remain unaware that their viewing time is being

recorded, but this requirement can raise ethical concerns and very serious practical issues.

The visual stimuli used for the task include pictures of children and adults. The procedure is based on the common-sense notion that subjects will spend more time looking at stimuli of individuals they find sexually attractive than of individuals that they do not find sexually attractive. Some, although not all, research studies have supported this hypothesis.[51] Moreover, as the variable being measured—viewing time—becomes more widely known, this evaluation procedure may become easier for subjects to fake.

Use of Assessment Results

The results of a well conducted juvenile sex offender risk assessment should provide sufficient guidance to assist both clinicians and legal professionals in reaching a disposition in the case. Although the report itself may not recommend a specific legal disposition, since that is the court's purview, the report may at least address issues that will assist the court in reaching a determination, such as a treatment plan and the juvenile's level of risk. The report should be sufficiently clear that a lay reader can determine what risk the juvenile presents, what risk factors were considered in reaching a risk assessment, and what treatment and security needs the juvenile has. The primary uses of an assessment, then, are:

1. Risk assessment: A risk assessment is obviously a key component in a juvenile sex offender evaluation. Clinical, criminal justice, and legal professionals involved with the juvenile need to have a clear idea of the risk the juvenile presents to others and the conditions under which such risk might be increased or decreased. Frequently, significant legal

conditions, such as incarceration or level of community notification, are predicated upon level of risk.

2. Level of supervision/security: Closely associated with level of risk is level of security. That is, can the juvenile remains in his home or must he be placed in an out-of-home setting. If allowed to remain in the community, what level of probation supervision must juvenile receive? If placed in a therapeutic foster home, how closely must the juvenile be supervised? Is the juvenile's risk so high that placement in a secure residential facility is needed? All these questions depend upon the level of risk the juvenile presents and the environmental circumstances that could help manage that risk.
3. Treatment plan: A clinical formulation of what aspects of the juvenile's personality led to the sexual offending leads, in turn, to a detailed treatment plan. For example, Worling notes[52] that individuals in each of the four cluster analysis groups he found require different treatment plan components. Those juveniles in the Antisocial/Impulsive group, representing almost half of Worling's sample, were the most likely to require a residential, secure setting. In addition, this group may not require the use of sexual reconditioning procedures, since it appears to be delinquency in general rather than specific deviant sexual interest that motivates much of their sexual offending. On the other hand, antisocial/impulsive juveniles could benefit from social skills training focusing on alternatives to aggression, such as self-control, avoiding

fights, and resolving conflicts, as well as on the development of positive bonds with healthy adult role models.

Overcontrolled/Reserved adolescents do not have the history of conduct problems and the antisocial orientation associated with last group. These adolescents, and the other hand, need assistance in modifying their shy, inhibited interpersonal style, perhaps focusing on exercises that encourage them to assert themselves and express their emotions.

Adolescents in the third group, Unusual/Isolated, present as peculiar, socially avoidant teenagers. These juveniles display the most idiosyncratic thinking, and lack healthy, intimate sexual relationships with a consenting peer. Consequently, in addition to traditional sex-offender-specific treatment, these juveniles would require modification of their perhaps schizotypal interpersonal stance.

Adolescents in the final group, Confident/Aggressive, present as friendly and confident, but also as aggressive and narcissistic. They are not likely to benefit from remedial instruction in basic social skills. Instead, they may need assistance in being less self-centered, perhaps through emphasis on victim empathy exercises and the cultivation of a softer, more considerate manner of relating to others.

4. Risk Management: As previously noted, risk management refers to the current interventions that can lower the immediate risk the juvenile presents of sexual offending. A comprehensive evaluation of a juvenile sex offender should include recommendations for risk management. In this regard, it is important to consider the juvenile's social environment, particularly the family environment, when the evaluator has access to this information. One characteristic that differentiates the treatment and management of juvenile sex offenders from that of adult sex offenders is the juvenile's heavy dependence upon his family. The admittedly scant research on the effectiveness of treatment for juvenile sex offenders suggests that in addition to a typical relapse prevention approach, the most effective treatment programs for juvenile sex offenders place heavy emphasis upon family involvement in treatment wherever possible.[53]

Conclusion

Juvenile sex offending is a serious social problem. Its effect on victims (including secondary victims, such as family members of the victim) is well documented. It damages the family of the offender as well, emotionally, socially, and frequently financially. Moreover, incarceration of the juvenile offender is expensive for society, as is community notification regarding juvenile offenders in those jurisdictions where juveniles are subject to community notification. Legal and clinical professionals working with this population face the difficult decisions of managing this population: determining level of security, assessing appropriateness to remain in the community, and developing

an intervention and risk management plan. A comprehensive evaluation can provide valuable information to assist each of these determinations. While there are many similarities between evaluation of juvenile sex offenders and adult sex offenders, juveniles present unique issues: involvement of families and schools, consideration of the rapid developmental changes that occur in adolescence, and the need for a generally systemic approach to treatment and management. Assessing and managing risk are critical in dealing with adolescent sex offenders. A number of risk assessment instruments have been developed specifically for juveniles, and evaluators of this population should be aware of existing instruments and their properties.

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[1] S. Righthand & C. Welch. (2001). Juveniles Who Have Sexually Offended. Office of Juvenile Justice and Delinquency Prevention.
[2] Id.
[3] Id.
[4] Id.
[5] Id.
[6] Worling, J. R. (2001). Personality-based typology of adolescent male sexual offenders: Differences in recidivism rates, victim-selection characteristics, and personal victimization histories. *Sexual Abuse: A Journal of Research and Treatment, 13*, 149-166. Although Worling's study requires replication, he notes that his cluster analysis results are almost identical to the prior findings by Smith et al. See Smith, W. R., Montastersky, C., & Deisher, R. M. (1987). MMPI-based personality types among juvenile sexual offenders. *Journal of Clinical Psychology, 43*, 422-430.
[7] See discussion in Witt, P. H. & Dyer, F. J. (1997). Juvenile transfer cases: Risk assessment and risk management. *Journal of Psychiatry and Law, 25*, 581-614
[8] Worling, J.R. and Curwen, T. (2001). *Estimate of Risk of Adolescent Sexual Offense Recidivism, Ver. 2.0 Manual.* Etobicoke, ON: Thistletown Regional Centre.
[9] Hanson, R.K. (2000). *Risk Assessment*, Beaverton, OR: Association for the Treatment of Sexual Abusers.
[10] See Weibush, R. G., Baird, C., Krisberg, B., & Onek, D. (1995). Risk assessment and classification for serious violent and chronic offenders. In J. C. Howell, B. Krisberg, J. D. Hawkins, & J. J. Wilson (eds.), *A Sourcebook: Serious, Violent, and Chronic Juvenile Offenders* (pp. 171-212). Thousand Oaks: CA: Sage Publications. Also see Witt & Dyer, *supra* note 7.
[11] Hanson, R.K., and Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, 66, 348-362.

[12] Heilbrun, K. (1997). Prediction versus management models relevant to risk assessment: The importance of legal decision-making contexts. *Law and Human Behavior*, *21*, 347-359. See also discussion in Witt & Dyer, *supra* note 7.
[13] Heilbrun, K., Cottle, C., and Lee, R. (2000). Risk assessment for adolescents. *Juvenile Justice Fact Sheet.* Charlottesville, VA: Institute of Law, Psychiatry & Public Policy, University of Virginia.

[14] Hanson, R. K. (2002). Introduction to the special section on dynamic risk assessment with sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 99-101; Hanson, R.K. (2000). Supra Note 9; Rich, P. (2002). *Clinical Assessment of Juvenile Sex Offenders and Risk for Re-offending.* Paper presented at the National Adolescent Perpetration Network, Research and Treatment Conference, Toledo, OH.

[15] Please note that this kind of assessment is not intended to determine guilt or innocence. See National Task Force on Juvenile Sex Offending. (1993). Revised report. *Juvenile and Family Court Journal,* 44(4); Perry, G. P. and Orchard, J. (1992). *Assessment and Treatment of Adolescent Sex Offenders.* Sarasota, FL: Professional Resources Press; Ryan, G. and Lane, S. (1997). *Juvenile Sex Offending: Causes, Consequences, and Correction.* San Francisco, CA: Jossey-Bass.

[16] Hanson, *supra* note 14; Rich, *supra* note 14.

[17] For example, Hanson's work on the SONAR and Worling and Curwen's work on the ERASOR. See Hanson, R. K. & Harris, A. J. R. (2001). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 27,* 6-35; Worling and Curwen, *supra* note 8.

[18] Hanson & Bussiere, *supra* note 11.

[19] Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 169-194.

[20] Prentky, R., Harris, B., Frizzell, K. and Righthand, S. (2000). An actuarial procedure for assessing risk with juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 12,* 71-92.

[21] Juvenile Sex Offender Focus Group. (2001). *Understanding Treatment and Accountability in Juvenile Sex Offending: Results and Recommendations from an OJJDP Focus Group.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

[22] Langstrom, N. and Grann, M. (2000). Risk for criminal recidivism among young sex offenders. *Journal of Interpersonal Violence, 15*. 855-871.

[23] Hanson & Bussiere, *supra* note 11.

[24] Langstrom & Grann, *supra* note 22.

[25] Hanson & Bussiere, *supra* note 11.

[26] Langstrom & Grann, *supra* note 22.

[27] Worling, J. R. & Curwen, T. (2000). Adolescent sexual offender recidivism: Success of specialized treatment and implications for risk prediction. *Child Abuse and Neglect, 24*, 965-982.

[28] See Hanson, *supra* note 9; Campbell, T. W. (2000). Sexual predator evaluations and phrenology: Considering issues of evidentiary reliability. *Behavioral Sciences and the Law, 18,* 111-130; Rich, P. (2002). *Clinical Assessment of Juvenile Sex Offenders and Risk for Re-offending.* Paper presented at the National Adolescent Perpetration Network, Research and Treatment Conference, Toledo, OH.

[29] Modified from Hanson, *supra* note 9 and Rich, *supra* note 14.

[30] The standard personality measures that most clinicians are familiar with—such as the MMPI-II and MMPI-A, MACI and others—provide us with important information to understand the personality dynamics of the individual, but generally do not assist in determining level of risk of future sexual offending. Consequently, most sex offender evaluation specialists use tools specifically developed for this purpose.

[31] See Hanson, R.K. and Thornton, D. (1999). *Static-99: Improving actuarial risk assessments for sex offenders* (User Report 99-02). Ottawa: Department of the Solicitor General of Canada; Epperson, D. L., Kaul, J. D. and Hesselton, D. (1998). *Final reports of the development of the Minnesota Sex Offender Screening Tool-Revised (MnSOST-R).* Presentation at the 17th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Vancouver, B.C., Canada; Hanson, R.K. (2000). *Risk Assessment,* Beaverton, OR: Association for the Treatment of Sexual Abusers.

[32] See discussion in Worling, & Curwen, *supra* note 17, p. 1.

[33] Prentky, R., Harris, B., Frizzell, K. and Righthand, S. (2000). An actuarial procedure for assessing risk with juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 12,* 71-92.

[34] Worling & Curwen, *supra* note 17.

[35] Rich, *supra* note 14.

[36] Rich, *supra* note 14.

[37] Hanson & Thornton, *supra* note 31.
[38] Poole, D., Liedecke, D. and Marbibi, M. (2001). Risk assessment and recidivism. Juvenile Sex Offenders: A Validation of the Static-99. Paper presented at the 20th Annual Conference of the Association for the Treatment of Sexual Abusers. San Antonio, TX.
[39] Borum, P., Bartel, P. and Forth, A. (2002). *Manual for the Structured Assessment of Violence Risk in Youth*. Tampa FL: University of South Florida.
[40] See Witt & Dyer, Supra Note 7**;** Jessor, R., van den Bos, J. Vanderryn, J., Costa, F. & Turbin, M. (1995). Protective factors in adolescence problem behavior: Moderator effects and developmental change. *Developmental Psychology*, *31*, 923-933.
[41] Additionally, the results of two unpublished studies available from the senior author also support the SAVRY's positive relationship to risk. There has been increasing interest in factors that protect adolescents from performing delinquent behavior. While conceptual interest in protective factors dates back two decades (for example, Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder, *British Journal of Psychiatry*, *147*, 598-611.), until recently no instruments were designed to assess these protective factors in adolescents. The SAVRY is one of the few instruments that specifically assess protective factors. The Children and Adolescent Risk for Violence (CARV) is another such instrument, on that also has at least preliminary validity data (see Seifert, K, Phillips, S., & Parker, S. (2001). Child and Adolescent Risk for Violence (CARV): A tool to assess juvenile risk. *Journal of Psychiatry and* Law, 29, 329-346.) The Protective Factors Scale (Bremer, J. (2001) Manual for the Protective Factors Scale. St. Paul, MN: Project Pathfinder, Inc.) takes the novel approach of suggesting levels of intervention based on factors that inhibit harmful sexual behavior. Although not a risk assessment instrument, per se, it is helpful in making placement and/or treatment decisions. Although the Protective Factors Scale purports to measure protective factors, a review of its criteria suggests that many factors measured are in fact risk factors, such as level of compliance, school attendance, and quality of peer relationships.
[42] Quinsey, V. L. & Lalumiere, M. (2002). Assessment of Sexual Offenders Against Children. Thousand Oaks: CA: Sage Publications. Citation omitted.
[43] Id.
[44] Id.
[45] Id. Also Emerick, R. L. & Dutton, W. A. (1993). The effect of polygraphy on the self-report of adolescent sex offenders: Implications for risk assessment. *Annals of Sex Research*, *6*, 83-103.
[46] Quinsey & Lalumiere, *supra* note 42.
[47] Quinsey & Lalumiere, *supra* note 42.
[48] Quinsey & Lalumiere, *supra* note 42.
[49] Association for the Treatment of Sexual Abusers Professional Issues Committee. (2001). Practice Standards and Guidelines. Beaverton, OR:Association for the Treatment of Sexual Abusers.
[50] Quinsey & Lalumiere, *supra* note 42, p. 39.
[51] See discussion in Quinsey & Lalumiere, *supra* note 42, pp. 39-40.
[52] Worling, s*upra* note 6.
[53] Worling & Curwen, *supra* note 27.