Current Research With Youth: A Reader's-Digest Overview of What's New

MnATSA

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Welcome!

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Predicting the future: a rich tradition

- Astrology
- Palm-reading/phrenology
- Tarot cards
- Crystal balls
- Tea leaves
- Bones, coins, yarrow sticks, I Ching, etc.
- Clinical opinion

Healing people: A rich tradition

- Leaches
- Bloodletting
- Trepanning
- Lobotomy
- More recently, in the early 20th century, some “cures” for alcoholism contained alcohol
  - (from Slaying the Dragon)

Who are they?

Alexander (1999)

- Meta-analysis, included juveniles
- N=1025
- Recidivism for treated (no data on untreated)
  - Rapists - 5.8%
  - Child molesters - 2.1%
  - Unspecified - 7.5%
- Varying length of follow-up, but “Recidivism rates grew over time with juveniles...”

Epperson et al. 2004

- Still in progress; Reported at NAPN
- N = 637
- Recidivism = arrest for a new sex offense prior to age 18
- Base rate = 13%

Vandiver, 2006

- 300 registered male offenders; <18 at the time of their arrest (avg. was 15)
- 3-6 year follow-up
- *N* = 13 arrested for a sex offense
  - Of those, 4 arrested 2x & 1 arrested 3x
- More than 50% arrested for non-sexual crime

Caldwell, 2007

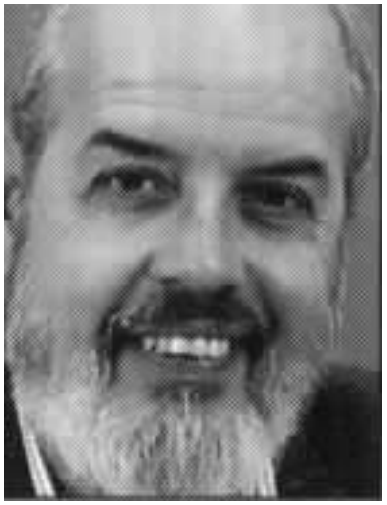
- Examined recidivism rates of 249 YSA and 1,780 non-sexual “delinquents.”
- 5-year follow-up for sexual recidivism
- 6.8% for YSA
- 5.7 for delinquents
- Non-significant difference
- 54 homicides, none by YSA

Implications

- Many adolescents who have engaged in illegal behavior subsequently cause sexual harm.
- Sexual re-offense is only one way to understand the effects of treatment.
  - We need person-centered approaches that establish healthy future goals across the lifespan, and not just reducing sexual re-offense risk.

Quinsey et al. (2004)

- Best predictors of juvenile delinquency among general youth, 6-11 (p. 91):
  - Prior offending
  - Substance use
  - Being male
  - Low socioeconomic status
  - Antisocial parent



Quinsey et al. (2004)

- Best predictors of juvenile delinquency among general youth, 12-14 (p. 91):
  - Lack of strong prosocial ties
  - Antisocial peers
  - Prior delinquent offenses

  - *"Theories to account for the patterns of these markers tend to focus on narrow domains. In the absence of a more general theory, the wealth of correlates... that are themselves intercorrelated is somewhat of an encumbrance rather than a benefit."*

Quinsey et al., 2004; Moffitt, 1993

- 3 groups of delinquent adolescents:
- Adolescence-limited
  - begins in adolescence; desists by adulthood
- Early onset, life-course persistent with neuropathology:
  - pre/peri/post-natal problems, sometimes in combination with family and community adversity
- Early onset, life-course persistent w/o neuropathology:
  - *"…a discrete class of individuals, a taxon that is different in kind from other antisocial individuals…"*

Sexual Aggression in College Men

- Abbey, McAuslan, et al (JIV, 2001) surveyed 343 college men. 33% reported having engaged in some form of sexual assault. 8% reported an act that met standard legal definitions of rape or attempted rape (p. 799).
- Koss, Gidycz, & Wisniewski (1987) found that 24.4% of college men reported “sexual aggression” since age 14, and that 7.8% admitted to acts that met standard legal definitions of rape or attempted rape (cited in White & Smith, 2004, CJB, p. 183)

Sexual Aggression in College Men

- Antonia Abbey & Pam McAuslan (2004, JCCP, p. 752):
- *In this sample of male college students, 14% reported that they had committed a sexual assault within a 1-year time interval. This is quite close to the rate presented in the only other study to our knowledge that examines sexual assault perpetration among adults longitudinally, which found a perpetration rate of 12.5% between the 1st and 2nd year of college (White & Smith, in press). These results further demonstrate the critical need for effective prevention programs for men in college.*

- Caution: “sexual assault” not clearly defined

Prevalence

- Bottom line = it's big
- We need a public health perspective over and above psychological and criminological perspectives

- Victim-to-victimizer hypothesis = wrong
  - Self-report requires behavioral desciption...
  - See Simons (2007)

Worling, 2001

- Took 112 adolescents from a recidivism sample and cluster analyzed factor scores from California Personality Inventory. Four subgroups emerged:
  - Antisocial/impulsive
  - Unusual/isolated
  - Over-controlled/reserved
  - Confident/aggressive

Worling, 2001, *Continued*

- Results:
  - Antisocial/impulsive and Unusual/isolated were more likely to engage in sexual, violent, and general recidivism.

- Author noted that striking similarities to the only other study of its kind with juveniles (I.e. Smith, Monastersky, and Deisher, 1987, using MMPI protocols)

Base rates, *continued*

- Långström and Grann (2000)
  - N= 46, age 15-20, various locations (e.g. prison, forensic psychiatric, probation, but all received court-ordered forensic evaluations
  - 72 month follow-up
  - Sexual recidivism = 20%
  - Violent recidivism = 22%
  - General recidivism = 65% **(including violence)**

(Journal of Interpersonal Violence, August 2000)

Predictive correlates in Långström and Grann (2000)

- **Sexual recidivism (risk ratios significantly higher that 1.0, 90% CI):**
  - **Any previous sex offending behavior (including convictions)**
  - **Poor social skills**
  - **Any male victim**
  - **2 or more victims in index offense**

  Note: translated into a 4-point scale, the average recidivist had 2 points (SD= .87, range 1-3), while non-recidivists had .76 (SD= .83, range 0-3). Scale based on a 2-year follow-up. The ROC was .84 (95% CI .70-.94)

Predictive correlates in Långström and Grann (2000)

General Recidivism (risk ratios significantly higher that 1.0, 90% CI)

- Signs of Conduct Disorder (DSM-IV) before age 15

  (Not including sexually abusive behaviors)

- Any violent conviction
- 3 or more previous convictions for any crime
- Psychopathy (in Sweden = 26 and above on PCL-R
- Use of death threats or weapons in index offense
  - Note: translated into a 5-point scale, the average recidivist had 2.03 points (SD= 1.71, range 0-5), while non-recidivists had .81 (SD= 1.22, range 0-3). Scale based on a 2-year follow-up. The ROC was .74 (95% CI .59-.87)

Base rates, *continued*

- Långström (2000, in press)
  - N= 117, age 15-20, various locations (e.g. prison, forensic psychiatric, probation, but all received court-ordered forensic evaluations
  - 168 month follow-up (14 years)
  - Sexual recidivism = 30%
  - Violent recidivism = 42%
- Author notes that sexual recidivism reduced considerably at 5 years, but that violent recidivism continued

Predictive correlates in Långström (2000, in press)

- Sexual recidivism (risk ratios significantly higher that 1.0, 95% CI)
  - Any previous sexual offending behavior
  - Sex offense in a public area
  - Any victim was a stranger
  - Offending on 2 or more occasions
  - Offending against 2 or more victims

  Note: in this study, victim penetration was associated with a <u>decreased</u> likelihood of reconviction

Predictive correlates in Långström (2000, in press)

- Violent Recidivism (risk ratios significantly higher that 1.0, 95% CI)
  - Signs of Conduct Disorder (DSM-IV) before age 15 (Not including sexually abusive behaviors)
  - Any prior violent conviction
  - Any victim penetration
  - Use of death threats or weapons
  - Physical injury of victim
    - Note: in this study, PCL-R scores were not available

Holy Cow!

We better register them!

Not so fast

- Letourneau and Armstrong (2008)
- First study to test whether registration corresponds to higher or lower rates of sexual and nonsexual re-offense.
- 111 pairs of registered and unregistered adolescents matched in areas such as age at offense, year of offense, race, prior crimes against people, and prior crimes not directly involving other people (e.g., property offenses).
- *Despite a follow-up period averaging 4.3 years, there were only two instances of sexual re-offense.*

Letourneau & Armstrong, cont.

- The authors also describe three other studies examining registered and unregistered adult sexual offenders. They note that none of these studies showed that registration reduces sexual re-offending, and that only one of the studies showed that registration resulted in more rapid arrest of those who did re-offend. However, because this is the first study of its kind with adolescents, it is essential that further research replicate these findings.

Take-away message

- Professionals should avoid recommending registration.
- Professionals can be helpful by communicating what we know and don't know to others.
- It is likely that short-term efforts to reduce sexual abuse (e.g., treatment) are more effective than long-term efforts such as registration.
- We don't know the long-term effects of our policies.

Letourneau & Miner, 2005

- Describe and dispute three falsely held beliefs that influence the length and severity of legal and clinical interventions:

1. There is an epidemic of juvenile offending, including juvenile sex offending
2. Juvenile sex offenders have more in common with adult sex offenders than with other juvenile delinquents
3. In the absence of sex offender-specific treatment, juvenile sex offenders are at exceptionally high risk of re-offending.

Implications

- By holding on to these beliefs, professionals risk engaging in ineffective and potentially harmful practices.
- Don’t let media accounts of egregious but rare events (e.g., sexual murder) bias you.
- Adolescents who sexually abuse share many common features with other youths who commit crimes

Assessment

Viljoen et al, 2008

- Examined recidivism among 169 male YSA in residential programs
- Base rate 8.3% sexual recidivism
- Avg. time to recidivism was 100 months
- Neither JSORRAT—II nor SAVRY, nor JSOAP predicted sexual recidivism (total scores)

Hagan et al, 2008

- Studied 12 juveniles in Wisconsin who were recommended by experts for civil commitment but who ultimately were not committed.
- 42% sexual recidivism among these individuals, with a 5-year at-risk period.
- This figure is in contrast to the low rates of sexual recidivism reported in the general juvenile sexual research. This provides evidence that the capability to assess the risk in juvenile sexual re-offending may at times be higher than previously estimated.

What's missing?

Little, if any, research basis for:

- Remorse/Shame/Guilt
- Empathy
- Psychological Maladjustment
- Denial
- Clinical presentation
- In youth: Uncertain sexual arousal

  Hunter & Becker, 1994

Worling, 2006

- Studied three ways to measure sexual arousal and interest among adolescent males who acknowledged having sexual abused:
  1. A computerized analysis of how long the adolescent looks at each of a series of pictures of clothed people of both genders and varying ages.
  2. A self-report rating form for each of the same photographs.
  3. A simple graph in which the adolescents rated their sexual arousal for eight age categories, with one graph for each gender.

Worling, 2006

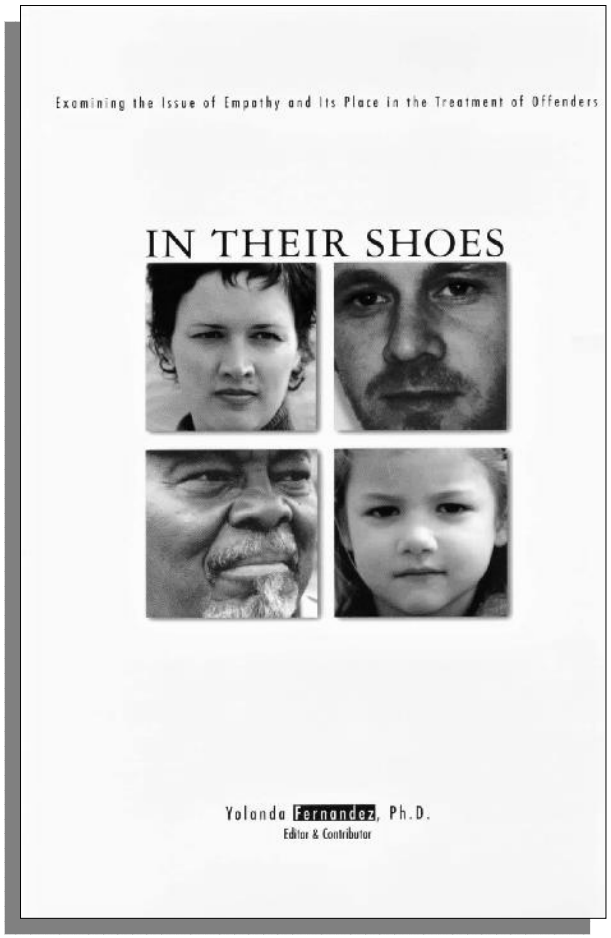
- Found similar patterns of responses to all three assessment techniques. The two self-report procedures distinguished those adolescents who abused children from those who abused peers or adults. The computerized assessment was able to distinguish those who had abused male children, but no technique accurately identified adolescents who had abused female children exclusively.

- Importantly, Worling also notes that earlier research into techniques such as the plethysmograph did not examine the adolescents' experiences of the procedure itself. In this study, Worling found that the adolescents typically did not find any of the methods upsetting.

Implications

- Adolescents can be truthful.
- Get back to the basics.
- Ensure person-centered practice.
- Assessment and treatment should address the person, not the behavior.
- There is much we don’t know about adolescent sexual interest and arousal.

Yolanda Fernandez, 2002



- Examining the issue of empathy and its place in the treatment of offenders
- Responsivity factor

Treatment

Worling and Curwen (1999)

- Followed two groups (treated and untreated) of youth who had sexually abused in Canada.
- N=148; Follow-up average of 6 years

- Found that treated juveniles had a 72% reduction in sexual recidivism, 41% reduction in non-sexual violence charges, and 59% reduction in non-violent, non-sexual recidivism.
  - Untreated recidivism: 18%
  - Treated recidivism: 5%

Walker, McGovern, Poey, & Otis (2004)

- Meta-analysis of 10 studies (N=644)
- “Results were surprisingly encouraging”
- Effect size – **r=.37**
- Cognitive-Behavioral approaches most effective

Reitzel and Carbonell (2006)

- Summarized published and unpublished data from 33 studies on JSA recidivism
- Average 56-month follow-up period
- 9 studies contained a no treatment control group (*n* = 4) or a comparison treatment group (*n* = 5)
- Treated adolescents recidivated sexually at a lower rate (7.37%) than untreated adolescents (18.93%; Total *N* = 2986)

Reitzel & Carbonell (2006)

- Average weighted effect size of **0.43** (*N* = 2986, 9 studies, *CI* = 0.33-0.55)

- *Translated into practical terms, this result indicates that for every 43 sexual offenders receiving the primary/experimental treatment who recidivated, 100 of the sexual offenders in the comparison group (i.e., those receiving comparison/alternative treatment or no treatment) recidivated.*

Reitzel & Carbonell (2006)

- Average weighted effect size for studies with a cognitive-behaviorally-based treatment was 0.59 (*n* = 819, 5 studies, *CI* = 0.13 - 2.71)
- Average weighted effect size for other studies was 0.41 (*n* = 2167, 4 studies, *CI* = 0.23 – 0.70)

Reitzel & Carbonell (2006)

- Recidivism rates (*N* = 5335, 4805 male)
- 11.87% sexual recidivism
- 22.59% non-sexual violent
- 28.99% non-sexual non-violent
- 22.30% unspecified
- (R = arrests, convictions)

Implications and a caution

- The higher rates of non-sexual recidivism demonstrate the need to provide more comprehensive treatment aimed at all forms of misconduct, not just sexual abuse.

- The right treatment approaches (primarily cognitive-behavioral and multi-systemic) with the appropriate client have a demonstrable positive impact on reducing recidivism.

- There has been no direct examination in the literature of treatment outcomes with youth who have refused, never started, or dropped out of treatment.

Caldwell, 2009

- Meta-analyzed 61 juvenile data sets
- 11,219 juveniles; weighted avg. 59.4 months
- Weighted mean sexual recidivism rate is 7.08%
- general recidivism 43.4%

"Studies that examine sexual recidivism during adolescence find monthly sexual recidivism rates that are more than 4 times higher than those found in studies that rely only on adult recidivism records. Neither the level of secured placement (community, residential, or secured custody) nor the use of arrest versus conviction as an outcome significantly influences sexual recidivism rates."

Assessing treatment progress

- Oneal, Burns, Kahn, Rich, & Worling (2008)
- *Treatment Progress Inventory for Youth who Sexually Abuse* (TPI-ASA).
- measures nine dimensions of adolescents with sexual behavior problems, including:

- inappropriate sexual behavior, healthy sexuality, social competency, cognitions supportive of sexual abuse, attitudes supportive of sexual abuse, victim awareness, affective/behavioral regulation, risk prevention awareness, and positive family caregiver dynamics

TPI-ASA, continued

The TPI-ASA will:

1. Expand ideas about treatment planning and assessing progress.
2. Provide professionals with common features to examine as they consider the progress of an adolescent with an emphasis on client strengths (these can be easy to lose sight of).
3. Establish a common language for dialogue across agencies. It enables professionals in one situation to understand better the work a young person has done in a variety of settings.
4. Offer a degree of objectivity to the difficult task of assessing treatment progress. This tool is based upon the expertise of many leaders in the field from both the literature and the practice of seasoned clinicians

Also!!!

Sue Righthand's Juvenile Sex Offense Specific Treatment Needs & Progress Scale, is another helpful instrument:

www.csom.org/ref/JSOProgressScale.pdf

Levenson & Prescott (2007): Treatment Effectiveness?

- Furby, Weinrott, & Bradshaw (1989).
  - Combined analysis of numerous studies that was unable to detect a significant treatment effect due to methodology variability.
- Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002).
  - 17% untreated
  - 10% treated

  -Equivalent to a 40% reduction
- Losel, F., & Schmucker, M. (2005).
  - Recidivism reduced by nearly 40%
- SOTEP:
  - No overall differences between treated and untreated groups, but:
- Sex offenders who <u>successfully completed</u> the SOTEP treatment program reoffended at lower rates than those who did not demonstrate that they "got it" (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005).

Tony Ward and "Readiness" (2004)

- Internal Readiness:
- Cognitive
- Affective
- Behavioral
- Volitional
- Personal identity

(To which DP would add psychiatric comorbidity)

- External Readiness:
- Circumstance
- Location
- Opportunity
- Resource
- Support
- Program/Timing

Tony Ward and “Readiness” (2004)

- Motivation of low readiness:

- Modify the client
- Modify the therapy
- Modify the setting

Other effect sizes

- Marshall & McGuire (2003) observe:
  - Bypass surgery for artery blockage = .15
  - Chemotherapy for breast cancer = .08
  - Aspirin for heart problems = .03

Other effect sizes

- Meyer, Finn, Eyde, Kay, Moreland, Dies, Eisman, Kubiszyn, & Reed (2001)
  - Antihypertensive medication and reduced risk of stroke has been found to be .03
  - Relapse prevention on improvement in substance abusers is cited as .14
  - Anti-inflammatory drugs have only a .14 correlation with pain reduction.
  - Nicotine patches demonstrate a correlation of .18 with smoking cessation

Other effect sizes

- Clozapine and its relationship to improvement in schizophrenia = .20
  - General knowledge is that only two thirds of patients with Schizophrenia respond to meds.

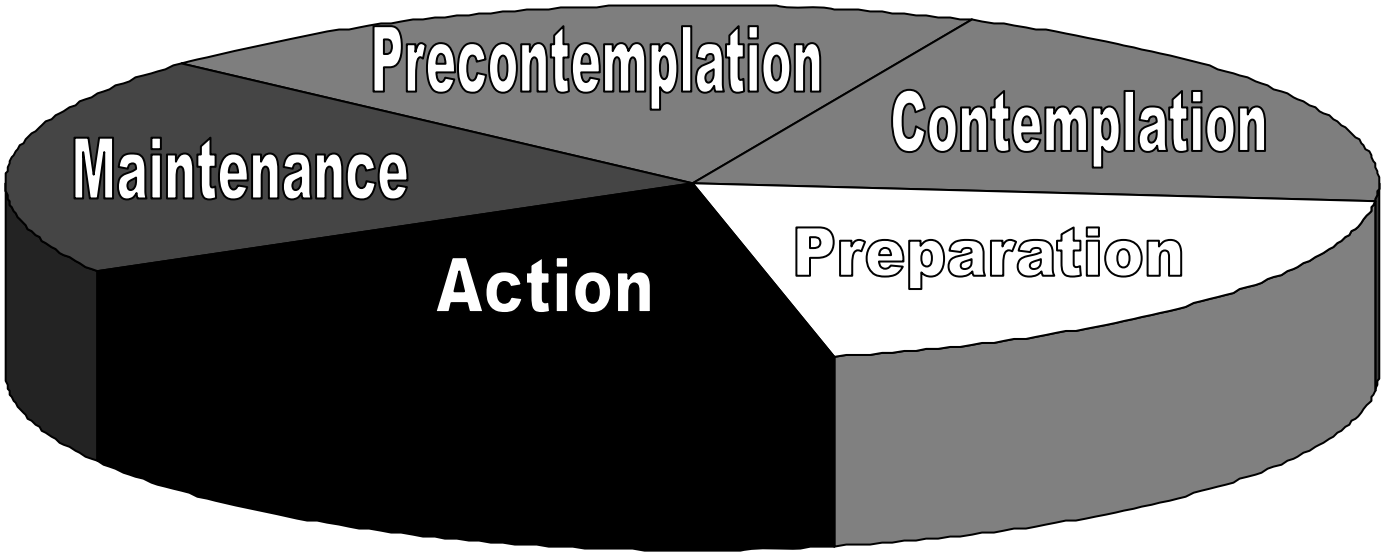
- Even Viagra, commonly thought of as a miracle drug, demonstrated only a moderate correlation with improved male sexual functioning (r = .38). Illustratively, the r squared (.14) indicates that Viagra accounts for only 14% of the variance in improvement in sexual functiong. Thus, statistical significance does not imply substantive significance.

Gretton, McBride, et.al. (2001)

- 220 JSO's; mean age at index offense of 14.7
- Scored on the PCL:YV and PPG
- Followed for a 55 month follow-up 15% sexual recidivists.
- Calculated the effect of the "deadly combination": high PCL and high deviance index.
- PCL and deviance predicted general and violent recidivism, but not sexual recidivism
- Caveat: Low numbers of PCL/PPG

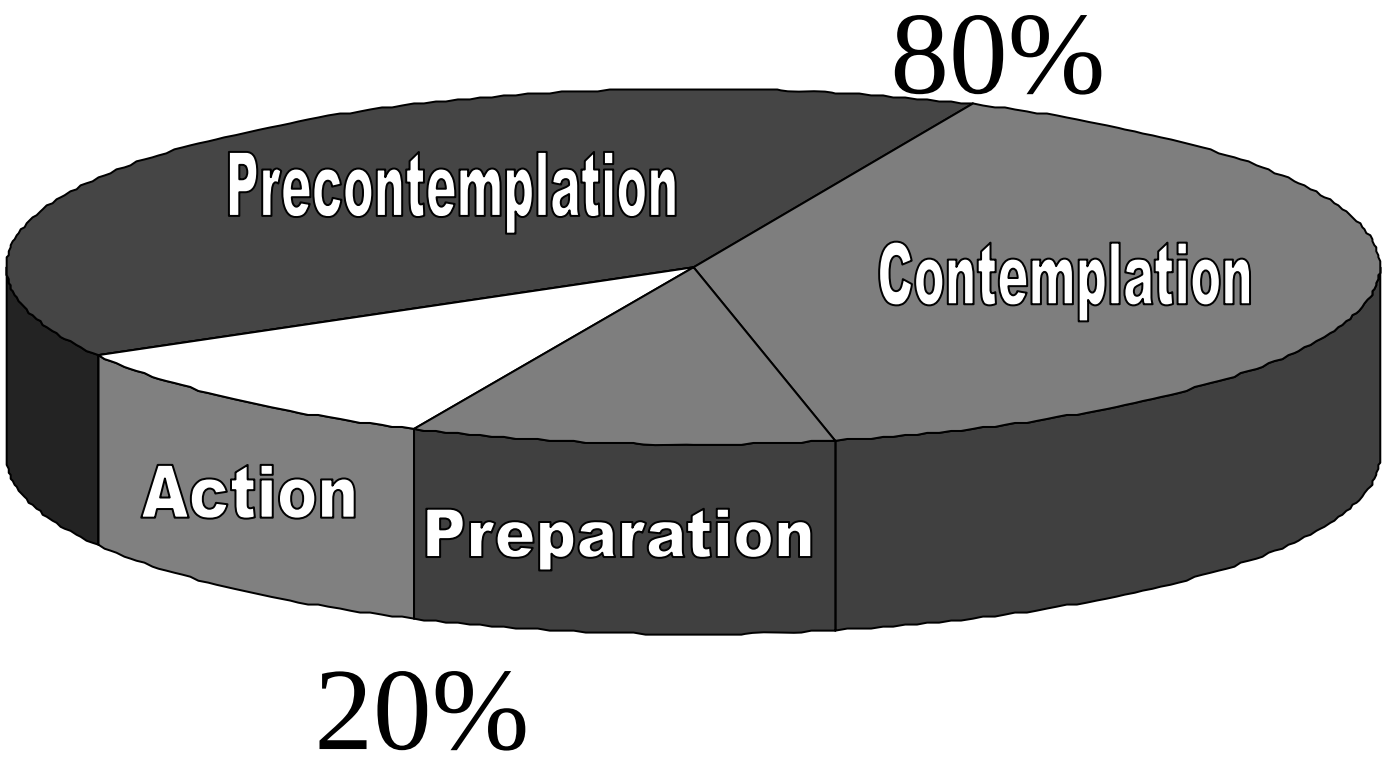
Stages of Change

Prochaska & DiClemente



Stages of Change

Prochaska & DiClemente



Arousal Reconditioning

- McGrath, Cumming, & Burchard, 2003:

- Male adolescent residential: 56.4% of programs use one or more behavioral techniques.
- Male adolescent outpatient: 49.4 of programs use one or more.
- Female adolescent residential: 48.5% of programs use one or more.
- Female adolescent outpatient: 37.2% of programs use one or more.

“Sexual Deviance”

- Understand sexual arousal in the broader context of emotional and physiological development.
- Understand the context of the harmful sexual behavior.
- Understand the developmental history of the youth, including harmful behaviors, as well as experiences with trauma or other developmental disruptions.
- Be careful with interventions targeting sexual deviance.
- Remember that all adolescents are sexual beings.

PPG: some cautions

- Standardization
- Changing arousal patterns
- No comparison to “normals”
- Some evidence that self-reported deviance is more predictive than objectively-measured deviance

Polygraphy: some cautions

- Youth are different in their treatment needs and willingness to disclose information.
- More information is not always better information
- Polygraph examinations have the potential to be re-traumatizing and may contribute to dysfunctional beliefs
- Young people may have long-term treatment needs, but the polygraph may only have short-term utility
- Disclosure is not always the same as honesty

Treatment Plan

- Problem: Coercive measures rarely work
  - Smith, Goggin, & Gendreau, 2002
  - Andrews & Bonta, 2003

- Goal: Efforts at change work best from within
  - Bem, 1972
  - Ryan & Deci, 2000; Deci, 1980
  - Miller & Rollnick, 2002
  - Jenkins, 1990; 1994; 2006
  - Cialdini, 2001

Hope Theory

- Agency Thinking
  - Awareness that a goal is attainable
- Pathways Thinking
  - Awareness of how to do it
    - See works by C.R. Snyder

- *"Therapists who are burned out or otherwise fail to convey hopefulness model low agency and pathways thinking."* (in Hubble, Duncan, & Miller, 1999)