Knowledge and practice with juveniles

David S. Prescott, LICSW
Marlboro, MA, 2011

Welcome!

CONTACT

David S. Prescott, LICSW
Clinical Director, Becket Programs Maine

"Healthy lives, safe communities"

VTPrescott@Earthlink.net
www.davidprescott.net

Focus

- What does the research say?
  - Who they are
  - Who we are
  - What's up with assessment
  - What's up with treatment

Bottom line

- Across time, place, & culture, adults have difficulty understanding and predicting the behavior of young people
- Aligning with natural developmental processes will likely produce the best results (i.e. medical model unhelpful)
- Everything we thought we knew 20 years ago was wrong.

Where we are: Summary

- Pro-crime attitudes and beliefs
- Interpersonal functioning
- Self-management
- Important others
  - Family, friends, community supports
- Abuse-related sexual interests

Logical public policy?

- Residence restrictions limit where an offender can live; most sexual abusers target people they know
- Therefore, limits on geographic location are meaningless; Sexual offenders can travel.
- Instead, we should not allow them to live near anyone they know
- Bonus points: to get really tough on crime, we should not allow them to live near anyone they may come to know in the future.

Who are they?

Seto & Lalumière, 2010

- *The results did not support the notion that adolescent sexual offending can be parsimoniously explained as a simple manifestation of general antisocial tendencies. Adolescent sex offenders had much less extensive criminal histories, fewer antisocial peers, and fewer substance use problems compared with non-sex offenders. Special explanations suggesting a role for sexual abuse history, exposure to sexual violence, other abuse or neglect, social isolation, early exposure to sex or pornography, atypical sexual interests, anxiety, and low self-esteem received support.*

Seto & Lalumière, 2010

- *Explanations focusing on attitudes and beliefs about women or sexual offending, family communication problems or poor parent–child attachment, exposure to nonsexual violence, social incompetence, conventional sexual experience, and low intelligence were not supported. Ranked by effect size, the largest group difference was obtained for atypical sexual interests, followed by sexual abuse history, and, in turn, criminal history, antisocial associations, and substance abuse.*

Implications

- Letourneau & Miner (2005) observed that adolescents who sexually abuse have more in common with other delinquent teens than they do with adult sexual offenders.
  - This is correct
- This study shows that there are still differences between populations of adolescents who sexually abuse and other teens who get in trouble with the law.

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; 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)

Palmer et al, 2010

- Surveyed 370 college students to explore the relationship between coercive sexual experiences, use of protective behavioral strategies, alcohol expectancies (i.e. what the user expected would happen by drinking alcohol) and the amount of alcohol consumption.

Palmer et al 2010

- 34% of the women and 31% of the men reported unwanted sexual contact while 6% of the women and 13% of the men reported engagement in sexually coercive behaviors.
- Victims reported greater alcohol consumption, increased negative consequences due to their use of alcohol and used fewer protective strategies.
- Students who used sexually coercive behaviors also reported greater alcohol consumption and noted significantly higher sex-related alcohol expectancies for the effect of alcohol on sex (e.g., beliefs that alcohol would decrease inhibition, reduce tensions and increase social pleasure).

Implications

- Very high correlation between alcohol use and sexual victimization/victimizing
- Exploration of this dimension for both victims and victimizers important in assessment
- Informative for prevention as well as treatment

Implications

- Embedded within alcohol expectancies are significant thinking errors by both victims and those who use coercive sex that precede the use of alcohol or drugs
- Exploring distorted values allows professionals to remediate substance abuse as a risk factor and work on permission-giving self-statements about alcohol abuse

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 decreased 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

Burton, 2008

- Identified 74 adjudicated youthful male sexual abusers and 53 nonsexual abusers and asked them a series of questions to look at the circumstances that may have led to the abusing behaviors. Each participant was given two tests (MACI and CTQ) to look at a number of risk and protective factors for each youth. Key findings included:
- Significantly more sexually abusing youth reported having been sexually abused (69.6%) than youth who have committed other crimes (39.6%)
- Personality characteristics (as documented in the MACI) contribute to the youth's decision to sexually abuse a younger child. Burton suggests that there are many reasons a teen may choose to abuse. The survey describes some of the reasons that youth make that choice including but not limited to meeting their own emotional needs.

Implications

- Understanding the role of victimization in the development of sexual behavior can be a challenge. Only a small number of sexual abuse survivors actually abuse others, and fewer still become repeat sexual abusers.
- However, Burton's study highlights that young people understand their own victimization in many ways and that personality (as well as developmental and contextual) factors can contribute to how young people understand their world.

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

Polygraphy

- Safer Society 2009 survey, over 50% of the responding programs claim to use polygraphy with adolescents.
- Lack research to recommend using polygraphy with adolescents, especially given its potential negative impact on 1) the developmental trajectory of adolescents, and 2) the clinician's ability to establish trust and mutual respect with the adolescent, a cornerstone of effective treatment.

Why not polygraph?

- Hindman & Peters, 2001
- adolescents who had sexually abused and participated in polygraph examinations reported twice as many victims as those who didn't.
- Authors touted "the power of the polygraph to elicit withheld information." Further, they observed that this finding was less dramatic than the results for adults, who reported five to six times as many victims as their adolescent counterparts.
- Results similar to those of an earlier study by Robert Emerick and Wendy Dutton in 1993, who also found a greater disclosure of sexually abusive and abuse-related behaviors when adolescents participated in polygraph examinations.

Polygraphy: 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

Implications

- **More research and discussion is needed.**
- Professionals will want to ensure that they are protecting the rights of their clients as well as those of people the client may have harmed.
- There are many considerations in using the polygraph….

Considerations

- Think twice before using a polygraph
  - **Kids are more vulnerable than adults!**
- Consider the potential downside impact (e.g., Are we undermining our own efforts to build rapport and provide guidance?)
- Explore what other alternatives may be available
- Decide whether it is clinically appropriate

Perhaps most importantly

- Acquiescence
  - Kids sometimes make things up in order to get through an interview
  - This can be a problem with our without the polygraph

Conclusion

- There is almost no research on the polygraph and its most effective use with adolescents. Just because professionals can use it with a given adolescent does NOT mean that they should use it. Policies that require polygraph examinations for every adolescent will likely do harm by neglecting the individual differences and vulnerabilities of each adolescent.

Chaffin, 2010

- Suggests that we should only use polygraphy IF it can be proven to:
  - lead to better treatment outcomes,
  - prevent future victimization, and
  - protect abusers from the all the consequences of abusing again.
- However, such research is currently lacking.

Chaffin, 2010

- Procedures to extract confessions seem to hold a particular sensitivity in the health care ethics literature, especially if the procedures are coercive or harsh. The World Medical Association (WMA; 1975) held that a breach could exist for health care providers by simply being present during harsh interrogations…

Chaffin, 2010

- *Interrogation-related ethics codes most directly pertain to out-and-out torture; however, they do also apply to psychologically coercive and degrading procedures. Specific procedures were listed by the APA (2008) in the wake of the Abu Ghraib and Guantanamo controversies over so-called "robust" interrogation. These included absolute prohibitions against mental health professionals participating in techniques such as the use of mind-altering drugs, exploitation of religious beliefs or psychopathology, fear tactics, simulated drowning or faked executions, and the use of humiliation. The ethics committee of the association will not consider any justifications that psychologists might offer for participating in any way in these practices (APA, 2009). The point of this paragraph is not to equate JSO polygraph interrogations with water-boarding but to demonstrate the heightened sensitivity with which the health care ethics literature views participation in interrogation.*

Chaffin, 2010

- *In a Chicago trial, MST was found to yield better outcomes than standard JSO group therapy (Letourneau et al., 2009). The standard therapy may have included routine polygraphy. State JSO practice standards for the standard therapy emphasized using the polygraph, required all treatment providers to have training in polygraphy, and strongly endorsed collaboration with polygraphers. Polygraphy was specifically waived for study youth who were randomized to MST. The findings are not a specific test of polygraphy itself but do demonstrate that alternative approaches can substantially improve outcomes without needing it.*

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.

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.

"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.

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.

PPG: some cautions

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

Sidebar: August, 2010

- PPG makes the national news in Canada after a study in the ATSA journal finds its benefits are questionable. BC Civil Liberties Union becomes involved.
- Concerns about exposing adolescents to erotic material
- *“Just because they can use it doesn’t mean they should.”*

Canadian Broadcast Corp.

- *Sex offenders as young as 13 were required to look at images of nude and semi-nude children and listen to audio descriptions of forced sex while their physical responses were measured.*
- *"It's been long recognized that the procedure is quite intrusive," Markwart said.*
- *The penile plethysmograph is a mercury-in-rubber strain gauge that is placed around the base of the penis and measures minute changes in penis circumference.*
- *Adult prisoners have referred to it as a "peter-meter."*

What’s missing?

Little, <u>if any</u>, research basis for:

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

  Hunter & Becker, 1994

Treatment

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.

Worling et al, 2010

- Followed 148 juveniles for 12-20 years
- Prospective study
- 16.22% sexual re-conviction rate (24 of 148)
- More likely to commit other crimes
  - *"Relative to the comparison group (n = 90), adolescents who participated in specialized treatment (n = 58) were significantly less likely to receive subsequent charges for sexual, nonsexual violent, and nonviolent crimes."*

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."

Good Lives model

- Jo Thakker, Tony Ward, and Patrick Tidmarsh in "Juvenile Sex Offender, V2:
- The overall premise is that an adolescent may continue to abuse because they:
  - 1. Lack life skills to prevent harm,
  - 2. Misapply the skills they do have,
  - 3. Have no reason to stop abusing, and
  - 4. Abuse in an opportunistic or deliberately planned manner

Thakker, Ward, and Tidmarsh recommend

- Identifying risk factors and categorizing them as either those that predispose one to abuse (e.g., chaotic home life), precipitate the abuse (e.g., an argument), or perpetuate it (e.g., social isolation). These factors suggest primary goods that can serve as treatment goals.
- Identifying protective factors, other areas of importance to the adolescent as positive goals to strive for. The treatment process helps the adolescent to work through factors that may impede progress.

Implications

- *Approach versus avoidance*. Approach goals have solid grounding in the research.
- *Development and context*. One shortcoming of this approach with adolescents is that it does not necessarily look at the environment and the context in which adolescent lives. The model offers little guidance for living with circumstances common to adolescents who have sexually abused, such as underlying psychiatric issues, the changing desires of adolescents, or the possibility of long-term group care.

Implications

- *Proceed with caution*. Our field has an unfortunate history of importing adult models carelessly. Often, these models have not considered the fact that the treatment needs of an adolescent can be very different from those of an adult. The authors are sensitive to many of the differences between adolescents and adults. However, the model has yet to receive extensive scientific study with adolescents of any age.

The problem with treatment

- In the past 15 years, a number of studies have indicated that putting adolescents who have engaged in misconduct together can actually increase their risk of committing further harm.
- Weiss et al (2005) examined this and found...

Weiss et al (2005)

- Examined published and unpublished studies of antisocial youth.
- Concluded that the presence of antisocial peer groups does not necessarily increase the likelihood of future misconduct. While the evidence is convincing that misbehaving youth can influence each other in general settings ("deviancy training"), this negative influence is not necessarily seen in group treatment situations.
- While the authors don't explicitly say so, it is interesting that most of the studied effects have more to do with whether adolescents take up smoking or behave poorly in the classroom than with future arrest for a serious crime. In one well-known study, the purported effects of these peer groupings were not apparent until 30 years later, and "treatment" involved mentoring and case management.

Implications

- The impact of peers is important.
- Positive Peer and Adult Influence.
- One study does not a reality make.

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 successfully completed 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).

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