Knowledge and practice with juveniles: Workshop for the PA SOAB

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Welcome!

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.

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)

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.

Robben Island

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)

Kurt Freund

- Czechoslovakia, 1940's
- Designed penile plethysmograph
  - Use in detecting homosexuality/false claims of homosexuality in the military
  - Volumetric device
  - Early studies rarely translated into English
  - Would emigrate to Canada in 1968 and join the Clarke Institute in Toronto

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."*

1974

- Martinson
- *Nothing Works*
- Later discredited
- Long since replaced by “what works”
- … But the damage was done!

- Let’s explore what’s happened since that time…

1978

- In 1978, Ed Brecher’s research found 20 SOTP in 12 states (only one was for JSA in Washington State).
- The Safer Society conducted national surveys beginning in 1986 and these surveys revealed the following growth patterns for JSA treatment programs.
- 1986 = 346
- 1988 = 573
- 1990 = 626
- 1992 = 755
- 1994 = 684
- 1996 = 539
- 2000 = 291
- 2002 = 937

Sidebar: 2010

- The 2010 Safer Society survey is available on-line

- An excellent overview of what’s happening in the field:

- http://www.safersociety.org/professionals/

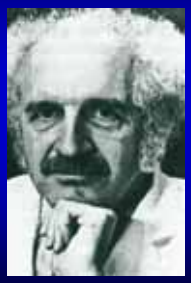
1986: What many thought

- Sexual offenders are destined to a lifetime of destruction and havoc

- Problem: prospective versus retrospective studies

Gene Abel

- 1960’s- Behaviorist roots, becomes interested in study of sexuality. Begins research with circumferential PPG
  - Easier to use than volumetric, less prone to movement artifacts
- While at the U of Mississippi, meets Judith Becker



Problem

- Up to this point, treatment approaches very behavioral
- Little discussion of how sexual offender treatment can:
  - Assist survivors
  - Increase accountability
  - Improve lives

Meanwhile, in Oregon

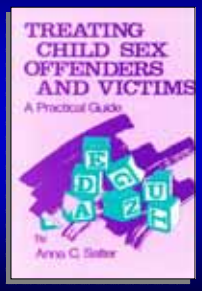
- Robert Longo, James Haaven, Jan Hindman and others become increasingly concerned by:
  - Need for knowledge in assessment / treatment
  - Concerns around use of PPG
    - e.g. exams of 8 hours duration, use to "establish" guilt or innocence, etc.

Jan Hindman

Who would later become President and first female board member, commented:

"All of a sudden the problem (of sexual abuse) had 'arrived' and plethysmographs started to appear all over the Northwest… After the well-established effort at the 41-B program, there followed a time of competition and conflict as others, without training, without scruples, purchased plethysmographs and jumped on the band wagon."

Anna Salter (1988)



- Sexual deviance versus sexual behavior to meet non-sexual needs
- Clear understanding of victim impact
- Numerous appendices included scales often used with youth
  e.g. Abel/Becker, BDHI, IRI

1990's: The rise of manuals

- Attempts to standardize treatment, inc. sequence
- Highly influential to many
  - e.g. Kahn's Pathways
- Inadvertent "cookie cutter" approach
- Inadvertent creation of investment in "there is a right way and a wrong way"
- None empirically tested

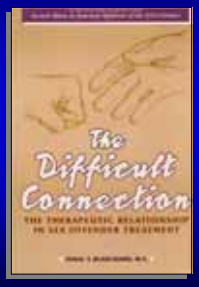
1992: "assessment"

- Based on adult version
- Included numerous scales with no psychometric properties
  - e.g. Phase
- Covers numerous areas with little advice on drawing conclusions
- Still in print and unrevised

Mid-1990's: Ryan & Lane

- Keywords:
  - Developmental-Contextual approach
  - Continuum of care
- Accompanied National Task Force and its "Assumptions"
- 2nd edition, 2010

1995: Therapeutic engagement



- 1st book on topic for this population
- 55 pages of text (!)
- Not widely cited
- Observes: *"Many... want to believe there is a right way and a wrong way to treat sex offenders... Many times our own investment in a treatment program fosters competitive jealousy toward practitioners who use a different model."* (p. 51)

Smith, Goggin, & Gendreau, 2002

- Meta-analyzed 117 studies since 1958 (n = 442,471 criminal offenders)
- No sanction studied reduced recidivism (including juveniles)
- "Prisons and intermediate sanctions should not be used with the expectation of reducing criminal behaviour."
  - Includes intensive surveillance, electronic monitoring, DARE, Scared Straight, etc.
  - Some indication of increased risk for low-risk criminals
  - www.ccoso.org

Myth: Treatment Doesn't Work Facts: Treatment can help

- 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).

Can they be cured?

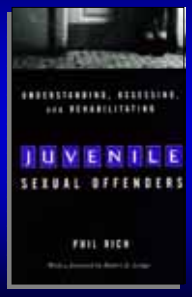
- Treatment won't work equally well for everyone, and 100% success should not be expected.
- Sex offender treatments, like many other types of medical and mental health interventions, don't focus on a cure but on a reduction of symptoms.
- Treatment for diabetes doesn't cure the disease, it manages the disease. Likewise, entering weight watchers with the expectation that simply being in the program will create weight reduction won't work. It takes collaboration and commitment.
- Appendix removal versus weight loss
- Auto Mechanic versus Home Depot manager

(from Kevin Creeden)

Can they be cured?

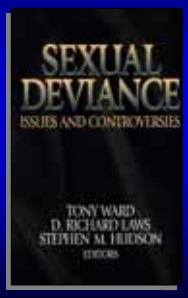
- Treatment for schizophrenia doesn't cure psychosis, it reduces symptoms and allows people to function more adequately.
- Chemotherapies may not ultimately prevent all cancer fatalities but may increase life expectancy and quality of life for many patients.
- Sex offender treatment teaches clients how to change their thinking and their behavior, and many are able and willing to do so and avoid reoffense.
- Treatment is just the road map; meaningful personal change is the goal (-- Sand Ridge patient)

2003: Phil Rich



- Most "juvenile sex offenders" not sexually deviant
- Assessment and treatment should target the entire youth
- Strong clinical focus; organized approach

2003



- "Good Lives" model both augments and challenges Relapse Prevention
- Approach/Avoidance pathways
  - different in pathways to first and subsequent offense

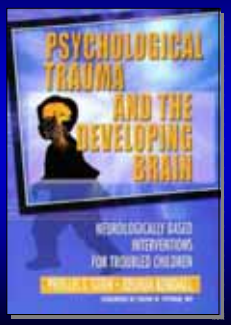
2003

www.resourcesforresolvingviolence.com

- Joann Schladale, self-published
- Narrative-influenced, invitational stance
- Situates abusive behavior in "Trauma Outcome Process"
- Framework for including other treatment elements
- Invites youth to be the person they want to be

Stien & Kendall (2004)

- Haworthpress.com
- Easy reading for a professional text
- Covers developmental aspects
- Focus on understanding trauma
- "Healing the brain"



2006: Current Perspectives

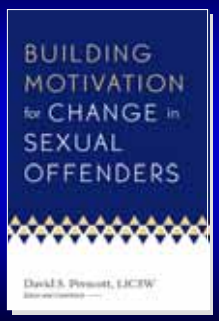
- Longo & Prescott
- 29 Chapters
- Neari.com
- Increasing evidence base
- New approaches to therapeutic engagement
- 1st risk assessment scale for adolescent females

2006: Risk Assessment

- Woodnbarnes.com
- Chapters by Douglas Epperson, Janis Bremer, Dennis Doren, Patricia Coffey, and others
- Contains the J-SORRAT – II, Protective Factors Scale, and a dynamic risk framework

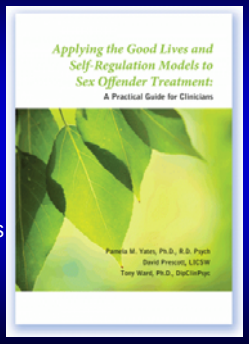
Should it interest…

- Recent release
- Very few resources on topic
- Chapters by Ward, Marshall, Marshall, Mann, Serran, Wilson, etc.



Also…

- Yates, Prescott, & Ward, 2010
- Practical guide for clinicians on good lives and self-regulation models
- Contains case examples with motivational enhancement



The role of the media

Sample and Kadleck (2006)

- Themes of high recidivism rates were consistently apparent throughout news articles.
- Sex offenders were commonly portrayed as persistent in their behavior despite punishment and rehabilitation.
- An "increase in news accounts of sexually-motivated homicide [which] could well support public perceptions that sex offending is often synonymous with murder" (p. 20).
- The media can "affect public perception regarding the prevalence of sex crimes by over-reporting single incidents of behavior" (p. 8).

The role of the media (Sample & Kadleck, 2006)

- Interviewed 25 politicians in Illinois, who agreed that sex offenders were a "growing" problem.
- Most politicians described sex offenders as "sick," commonly characterizing them as compulsive, persistent, and irredeemable, and none thought that rehabilitation was possible.
- When asked how they customarily obtained knowledge regarding sex offenders, the politicians cited the media as – by far – their primary source.
- Thus, the media appears to play a leading role in shaping opinion both among politicians and their constituents. As a result, public policies are proposed which are designed ostensibly to protect the public but which are more likely to promote only an illusion of safety.

Who are they?

Learning Difficulties

Hyperactivity

Communication Difficulties

Epperson et al. 2005

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

- See Prescott, 2005 for complete report and JSORRAT-II

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 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

Let's polygraph 'em

- 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
- 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

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.

Kids need adult supervision

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

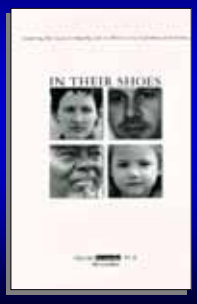
- McGrath, Cumming, & Burchard, 2003:
- Male adolescent residential: 56.4% of programs use one or more behavioral techniques.
- Male adolescent outpatient: 49.4 of programs use one or more.
- Female adolescent residential: 48.5% of programs use one or more.
- Female adolescent outpatient: 37.2% of programs use one or more.

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

Yolanda Fernandez, 2002



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

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).

Tony Ward and "Readiness" (2004, 2009)

- 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, 2009)

- 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)

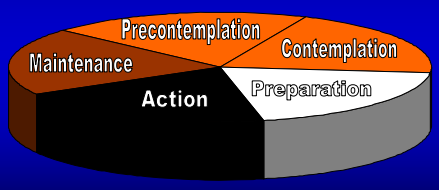
- 220 JSO's; mean age at index offense of 14.7
- Scored on the PCL:YV and PPG
- Followed for a 55 month follow-up 15% sexual recidivists.
- Calculated the effect of the "deadly combination": high PCL and high deviance index.
- PCL and deviance predicted general and violent recidivism, but not sexual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

Welcome back

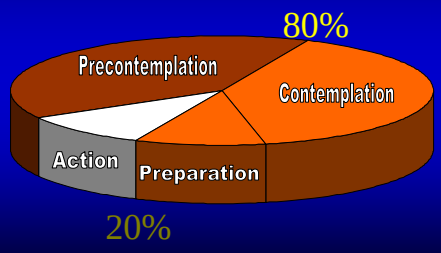
Motivational Enhancement and Treatment Structure

Stages of Change

Prochaska & DiClemente



Stages of Change
Prochaska & DiClemente



Case example

Meet Ethel

The problem behavior:
Chronically raiding the garbage

Presenting for treatment:
Resigned Precontemplation

Presenting for treatment:
Rebellious Precontemplation

Contemplation

Determination

Action

Re-Offense

What makes kids so special?

- Youthful idealism
- Lopsided development
- The "I'm not gonna you can't make me" sandwich

Remember…

- *The cake of contemplation is frosted with precontemplation!*
- SOC model nice in theory, but doesn't adequately account for developmental or contextual factors (e.g., Sutton, 2001)

Implications

- Aligning with natural developmental processes
- Teaching accountability rather than holding kids accountable
- Eliciting internal motivation for change
- Encouraging kids to stand up for what is right rather than fighting their efforts to do this.

Returning to the basics

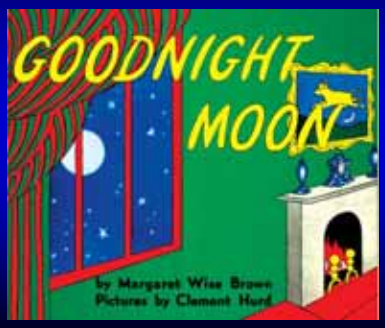
- Not everyone is ready to change, and some people change despite our efforts
- Readiness
- Responsivity

3 authoritative texts for understanding youth...

Runaway Bunny

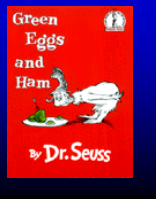
- Ambivalence
- Discrepancy between current and desired states
- Developmental aspects of relationships
  - Safety, predictability
- Etc.

A calm and soothing approach



Communication problems

- Closed ended questions
- Persistent persuasion guaranteed to build resistance
- Just plain irritating
- Worth a closer look...



Robben Island

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)

MI: Two recent perspectives

- *Motivational interviewing involves helping patients to say why and how they might change, and is based on the use of a guiding style* – Steve Rollnick, 2/28/10
- *Motivational interviewing uses a guiding style to engage with patients, clarify their strengths and aspirations, evoke their own motivations for change, and promote autonomy of decision making* – Rollnick et al, 2010

The Spirit of Motivational Interviewing

- Collaboration
- Evocation
- Autonomy

Four General Principles

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support Self-Efficacy

Getting Moving: OARS

- Open questions
- Affirmations
- Reflections
- Summaries

Reflective listening

- Simple Reflection
  - Exact words
  - Closely related words
- Complex Reflection
  - Continuing the paragraph
  - Reflecting emotion

Assessment-Driven Treatment

- Sexual deviance
- Contributory attitudes
- Socio-Affective functioning
- Self-management
- (Influential others)

Treatment planning

- Laundry list of risk factors?
  - Are we teaching to the test?
- Personally meaningful goals
- Combine phase goal matrix with SMART goals that client can work on

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

Perspectives

- "It is the truth we ourselves speak rather than the treatment we receive that heals us."
  - - Mowrer
- "People are generally better persuaded by the reasons which they themselves have discovered than by those which have come into the minds of others"
- - Pascal's Pensees, 17th Century

Imposed avoidance goals: No more offending	Shared-Vision approach goals: Healthy lives, safe communities

A comparison of imposed client-only goals and shared-vision goals: The best treatment plans are collaborative

Parallel Process

- Professionals and clients alike are often more willing to learn new skills than to throw out the old ones that don't work. Worse, sometimes our negative skills actually do work sometimes...

Phase Model

- Phase One: Self-management issues, including managing treatment-interfering factors.
- Some areas of ambivalence:
  - Do I really want to change?
  - Do I really want to give up Old Me?
  - Do I really want to work with others?
  - Do I really want to depend on others?

Phase Two

- Developing an understanding of one's life and an agreed-upon history of sexual offending
- Some areas of ambivalence:
  - Do I want to understand my life differently?
  - Do I want to look at the harm I've caused?
  - Do I want to discuss shameful aspects with others?
  - Do I want to develop new attitudes?

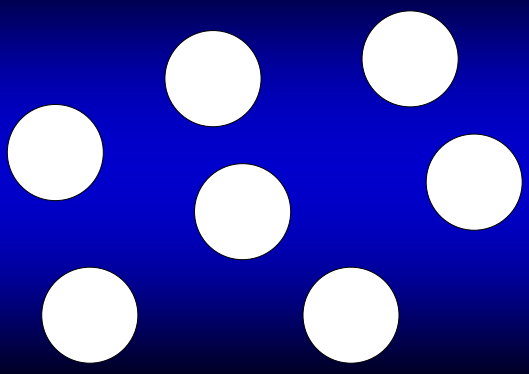
Phase Three

- Refine understanding of factors that contributed to offending and manage them in daily life, in the here and now.
- Some areas of ambivalence:
  - Do I really want to develop new skills?
  - Do I really want to give up old ways?
  - Do I really want to give up my fantasy repertoire?

Applications group

- Establish an "options menu" of areas where the client is having difficulty moving forward
- Offer the client a choice of which area he would like to explore
- Explore good and not-so-good things about the status quo and change

Options Menu



Good/not-so-good things about change

+ -

Guidelines for Offering Feedback

- Ask Permission
- Encourage Self-assessment
- Limit the Amount of Feedback
- Be Specific
- Include the Mentee's Agenda
- Respect Readiness
- Avoid Personal Affronts
- Balance the Feedback

Discussion

- Offer
- Explore
- Offer
- Explore
- Offer
- Explore
- Offer
- Explore

- Offer
- Explore
- Offer
- Explore
- Offer
- Explore
- Offer
- Explore

Individualized treatment group (ITG)

- Alternative group for those who demonstrate:
  - Persistent disruption and disrespect
  - No application of treatment material to daily life
  - Low motivation for change
- Target behaviors must have persisted despite attempts to re-engage, and psychological testing rules out other potential confounds

ITG

- Open-ended
- Intended to be brief
- Not a substitute for treatment program
- Patients use open-ended questions; harsh & confrontational stance not allowed

Format

- Client and treatment team outline issues to address
- Client enters these into a non-hierarchical options tool and chooses which issues he will address first
- Facilitator begins exploration of first focus issue using readiness ruler
- Facilitators begin to develop discrepancy
- Group members offer support and feedback

Format

- Cost-benefit analysis
- Exploration of ambivalence
- Beginning action planning and practice
- Feedback, etc.

- Fundamental value: ITG exists for *discussing* issues, not *debating* them.

Discussion includes

- How has this issue played a role in your past behavior?
- How does this issue play a role in your current behavior?
- What kinds of payoffs do you get from this?
- And on the other hand, what kinds of difficulties is it bringing you?

It might also include…

- What is happening when you decide to engage in this behavior?
- What do you want to happen and what do you get?
- How might this issue affect others?
- How might one approach situations where this issue might arise and get what you need without this issue happening?
- If you were in my (or someone else's) shoes, what might you think about this issue? (other patients often have a number of contributions to add to this question)

Potential traps

- Debate (instead of dialog)
- Unrealistic expectations (wanting too much)
- Focusing on one patient to the exclusion of others (some patients ask for more attention than others)
- Negative spotlight (it can be easier to highlight problems than successes with this population)
- Etiology (understanding the origins of a problem are not the same as resolving it)

Potential traps

- *The negative spotlight trap.* With no spotlight on success, clients have fewer avenues for exploring what has worked in their attempts to get back on track.
- *Discrepancy hurdles.* Clients are sometimes ambivalent about discussing the discrepancies between their current and desired statuses.

Potential traps

- Adverse experiences and trust
- Adverse experiences with authority
- Therapist gender and abuse-related cognition
- Superficial participation
- Not sticking with the style
- Group engages in the "righting reflex"

For more information

- www.davidprescott.net
- Click on publications and scroll down through articles
- Or simply email me