Risk assessment of adolescents who have sexually abused

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Welcome!

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Focus

- What does the research say?
  - Who they are
  - Who we are
  - What's up with assessment
  - What's up with treatment
- JSOAP-II; ERASOR; JSORRAT-II

Why research is important

- Lilienfeld, 2007 on Potentially Harmful Treatments:
  - Scared straight
  - Boot camps
  - Facilitated communication with autistic children
  - "Holding" therapies for attachment issues
  - Recovered memory techniques
  - Expressive/experiential therapies for some clients (e.g., encouraging the expression of pent up anger in violence prone clients)

Implications

- Be very careful with:
  - Confrontational or scared straight techniques
  - Sexual-abuse cycle work with youth who lack the life experience even to have an established cycle
  - Manual-based techniques relying on written assignments for clients with severe learning disabilities
  - Group interventions with certain severely traumatized, mental health or developmentally disordered clients whose ability to function in groups is tenuous
  - Talk therapies with clients with severe auditory processing problems

Implications

- For years, the gold standard of "abuse-specific treatment was a confrontational style of cognitive-behavioral therapy administered within a group setting run by male and female co-therapists supported by arousal reduction techniques. Until relatively recently, those questioning the relevance of these approaches were too often dismissed. Lilienfeld's paper suggests that a one-size-fits-all approach using harsh confrontation in styles mismatched to the needs of clients can cause harm.

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.

Marshall, 2005

- Warm
- Empathic
- Rewarding
- Directive (guiding)

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

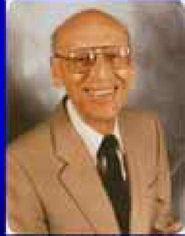
- Pro-crime attitudes and beliefs
- Interpersonal functioning
- Self-management
- Important others
  - Family, friends, community supports
- Abuse-related sexual interests

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.

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...

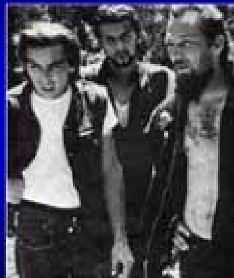
1978

- 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

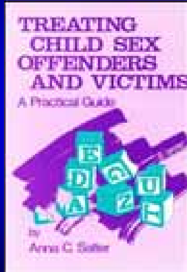
- Robert Longo, James Haaven, Jan Hindman and others become increasingly concerned by:
  - Need for knowledge in assessment / treatment
  - Concerns around use of PPG
    - e.g. exams of 8 hours duration, use to "establish" guilt or innocence, etc.

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

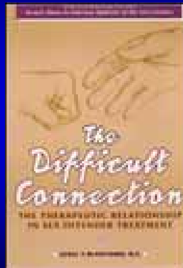
1992: "assessment"

- 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)

Sidebar

- In 2011, Colorado abandoned "no-cure" language in its state statutes

2002: Smith, Goggin, & Gendreau

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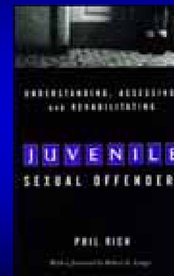
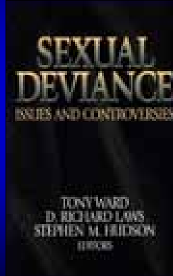
  http://ww2.ps-sp.gc.ca/publications/corrections/200201_Gendreau_e.pdf

2003: Phil Rich



- Most "juvenile sex offenders" not sexually deviant
- Assessment and treatment should target the entire youth
- Strong clinical focus; organized approach
- Revised 2010

2003



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

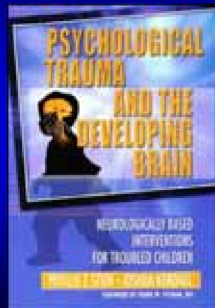
2003

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

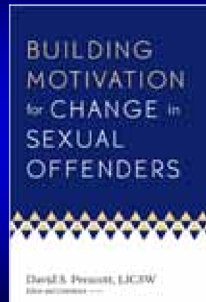
2006: Risk Assessment

- 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

How Dolphins Learn

2009: Should it interest…

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

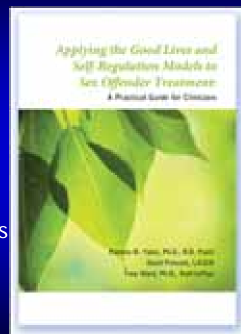


Hanson, Bourgon, Helmus, & Hodgins, 2009

- Examined sexual offender treatment and RNR principles
  - *Based on a meta-analysis of 23 recidivism outcome studies meeting basic criteria for study quality, the unweighted sexual and general recidivism rates for the treated sexual offenders were lower than the rates observed for the comparison groups (10.9%, n = 3,121 vs. 19.2%, n = 3,625 for sexual recidivism; 31.8%, n = 1,979 vs. 48.3%, n = 2,822 for any recidivism). Programs that adhered to the RNR principles showed the largest reductions in sexual and general recidivism.*

2010: Also…

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



2011: GLM V. RNR

Who are they?

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 = incomplete
  - Self-report requires behavioral description…
  - See Simons (2007)

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

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 <u>with</u> neuropathology:
  - pre/peri/post-natal problems, sometimes in combination with family and community adversity
- Early onset, life-course persistent <u>w/o</u> neuropathology:
  - *"...a discrete class of individuals, a taxon that is different in kind from other antisocial individuals..."*

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

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.

Carpentier et al., 2011

- Correlates of onset, variety, and desistance of criminal behavior
- Confirmed that most of those who persist commit a variety of offenses and don't specialize

Carpentier et al., 2011

- Early versus later starters
  - Early onset (before 12) more likely to have been violent and previously engaged in voyeurism, frottage, and compulsive masturbation
  - Greater levels of parental negligence
  - Parents more likely to have themselves been victimized
  - More likely to be aggressive throughout adolescence
  - Late starters were more likely to drop out of school

Carpentier et al., 2011

- Sex-only versus sex-plus aggressors
  - Sex-only have lower rates of CD and fewer antisocial traits
    - Less likely to have experienced traumatic physical and sexual victimization
    - Less likely to have been placed in outside care
    - Half as likely to have consumed alcohol and drugs prior to age 12
    - In adolescence, had less drug/alcohol, aggression, delinquent peers, and consensual sex

Carpentier et al., 2011

- Persisters
- Desisters
  - Fewer antisocial traits, less ADD, less physical and sexual victimization and parental negligence, fewer out-of-home placements, fewer learning disabilities, behavior problems, school failure. Also fewest consensual sexual experiences

Carpentier et al., 2011

- Stable Highs (sexual or violent re-offenses)
- De-escalators (re-offense, not sex or violence)
  - Less ADD, less physical and sexual victimization and parental negligence, fewer out-of-home placements, less involvement with delinquent peers. Fewer officially recorded crimes.

Carpentier et al., 2011

adolescent sexual aggressors who exhibited antisocial traits ran an almost threefold risk of committing both sexual and nonsexual offenses. Other studies of adolescent sexual aggressors have demonstrated a significant association between indices of antisociality and an increased risk of nonsexual (Parks & Bard, 2006; Worling & Curwen, 2000) and overall (Miner, 2002; Waite et al., 2005; Worling, 2001) recidivism. Gottfredson and Hirschi (1990) state that individuals with low elf-control have little ability to resist the temptation to adopt offending behavior when the opportunity arises and, furthermore, that this trait is stable over time.

Carpentier et al., 2011

Adolescents with poor self-control tend to avoid situations of social control (supervision, discipline) and consequently tend to associate with peers who resemble them and who, like them, are likely to offend. These young people also tend to experience school difficulties (behavioral and learning difficulties), leading to school failure and dropping out of school in favor of less constraining environments.

Carpentier et al., 2011

<u>the severity of the offenses committed by both these groups appears to be more influenced by childhood trauma</u> than by variables related to adolescent development. However, only two variables related to childhood development (sexual victimization and long-term paternal absence) predicted membership in the stable high group rather than the de-escalator group. In some ways, these findings support Moffitt's (1993) contention that individual and familial childhood characteristics are the variables with the strongest association with persistent and chronic antisocial behavior in adolescence and adulthood.
(emphasis added)

Carpentier et al., 2011

- We need to build resilience and protective factors to produce desisters
- Trauma treatment is vital
- Comprehensive assessments are key

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.

Letourneau & Miner, 2005

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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.

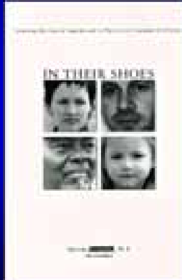
What's missing?

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

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."

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

Some Scales

- JSOAP – II
- ERASOR
- JSORRAT – II

JSOAP - II (available at www.csom.org)

- 4 scales:
  - Sexual Drive
    - (was sexual drive/pre-occupation)
  - Antisocial Behavior
    - (was impulsive, antisocial behavior)
  - Clinical Intervention
    - (was clinical/treatment)
  - Community Stability
    - (was community stability/adjustment)

Defined

- "A checklist whose purpose is to aid in the systematic review of risk factors that have been identified in the professional literature as being associated with sexual and criminal offending."
  - Not specific to sexual re-offense process
- Used with males 12-18, with histories of sexually coercive behaviors
  - (i.e. uncertain utility with non-coercive behaviors)
- Development sample
  - N = 75, with three recidivists after 1 year
  - IRR very good (+/- .83); subsequent improvements

Caveats

- *"Unlike adults, adolescents are still very much 'in flux'. No aspect of their development, including their cognitive development, is fixed or stable... In a very real sense, we are trying to assess the risk of 'moving targets'."*
- *"At the very least scales III and IV should be re-scored every six months."*
  - ... and more often as developments occur

Righthand et al. 2000

- Examined factor structure
  - Scale II (Impulsive, antisocial behavior)
    - 20% of variance
  - Scale III (Clinical intervention)
    - 20% of variance
  - Scale I (Sexual drive and pre-occupation)
    - 9% of variance
  - Scale IV (Community adjustment)
    - 8.5% of variance

Righthand et al. 2000, cont.

- Examined correlation with YLS/CMI
  - Total score r=.91
  - Scales: I=.37; II=.81; III=.88; IV=.91
  - Scale I correlated with number of sexual offenses, but had no correlation with total offenses

Predictive validity

- Hecker, Scoular, Righthand, & Nagle (2002)
- 54 male adolescent sex offenders
- Arrest and conviction data for 10-12 years
- 37% nonsexual recidivism (9=20)
- 11% sexual recidivism (n=6)
- Total JSOAP scores not correlated with sexual recidivism
- Scale I's AUC was .89
  - However, N was still only 6

Predictive validity

- Waite, Pinkerton, Wieckowski, & Brown (2002)
- 253 "very high risk juvenile sex offenders"
- 9-year follow-up
- Sexual re-arrest = 4.3% (n=11)
- General re-arrest = $\simeq$ 60%
- Low versus High modified scale II scores:
  - Any new arrest = 52.6% and 74.8% respectively
  - sexual re-arrest = 2.9% and 9.8% respectively
  - Caution! Small numbers = careful interpretation

Righthand, Knight, & Prentky (2002) 6 key findings

- Strong relationship between sexual abuse history and JSOAP scale 1
- Severity of sexual abuse was most important facet of sexual abuse for predicting outcome
- Family violence/Trauma and caregiver instability both related to JSOAP Scale II

Righthand, Knight, & Prentky (2002) 6 key findings

- JSOAP scale I strongly related to number of victims and victim gender
  - (higher score associated with male victim)
- JSOAP scale II related to victim age
  - (higher score associated with teenage and older)
- JSOAP scales I and II both associated with amount of force used

JSOAP - II Four factors

- **Factor 1: Sexual Drive**
  - Prior legally charged sex offenses
  - Number of sexual abuse victims
  - Male child victim
  - Duration of sex offense history
  - Degree of planning in sexual offense/s
  - Sexualized aggression
  - Sexual drive and pre-occupation
  - Sexual victimization history

JSOAP - II

- **Factor 2: Antisocial Behavior**
  - Caregiver consistency
  - Pervasive anger
  - School behavior problems (K-8)
  - History of Conduct Disorder
  - Juvenile antisocial behavior (age 10-17)
  - Ever charged/arrested before age 16
  - Multiple types of offenses
  - Physical assault history and/or exposure to family violence
    - NOTE: this factor based on CATS scale from VRAG

JSOAP - II

- **Factor 3: Intervention**
  - Accepting responsibility for offense/s
  - Internal motivation for change
  - Understands risk factors
  - Empathy
  - Remorse and guilt
  - Cognitive distortions
  - Quality of peer relationships

JSOAP - II

Factor 4: Community stability
(past six months)

- Management of sexual urges/desires
- Management of anger
- Stability of current living situation
- Stability in school
- Evidence of support systems

JSOAP - II Cautions

- Intervention items can be misleading
  - Lack of evidence for empathy, guilt, remorse
    - Do they exist in ALL domains?
    - Is empathy lacking for victims? In general?
    - Might be best to assess in light of other features
    - Affective versus verbal empathy, guilt, etc.
    - Might just be masked by poor rapport with assessor
    - Easy to over-interpret

JSOAP - II Cautions

- Intervention items can be misleading
  - "Cognitive Distortions":
    - Need to differentiate between permission-giving self-statements preceding abuse and defensive statements made after the fact.
  - "Peer Relationships":
    - Absence of antisocial peers not the same as having prosocial peers

JSOAP - II Reliability

- Good to excellent inter-rater reliability (e.g, Caldwell et al., 2008; Parks & Bard, 2006; Viljoen et al., 2008)
- One study failed to find acceptable inter-rater reliability for Scale 4 (Martinez, Rosenfeld, & Flores, 2007).
- Acceptable internal consistency for the scales (Parks & Bard, 2006).
  - One study found strong Total, Static, & Dynamic scale internal consistency, but variability among the subscales (.72; .74, .90, .69) (Martinez, Rosenfeld, & Flores, 2007).

JSOAP – II Predictive Validity

- *Total score* predicted general & sexual recidivism (AUC values were .76 & .78 respectively)
- Dynamic scales (AUC values were .74 [any] & .86 [sexual recidivism) outperformed static scales (.68 & .63 respectively)

(Martinez, et al., 2007)

JSOAP – II Outcome Studies

- Scale 2 significantly predicted sexual recidivism (Parks & Bard, 2006)
- Static scales together & Scale 1 predicted sexual recidivism (AUC values were .75 & .72 respectively, with Scale 2 AUC at .64) (Powers-Sawyer & Miner, 2009)

JSOAP – II Outcome Studies

- Viljoen et al 2007:
- JSOAP– II Total Score not predictive of post-treatment offending; Scale 2 approached statistical significance for serious nonsexual crimes
- Total JSOAP– II Total score & Scales 2, 3, & 4 were predictive of nonsexual offending during treatment to some degree (AUC values were .66, .63, .61, .67 respectively).
- Scale 1 was somewhat predictive of sexual recidivism during treatment (AUC value was .65)

- Elkovitch, Viljoen, et. al. (2008)
  - Based on the same data set, found:
  - Total scores on the J-SOAP-II were predictive of instrument-informed clinical judgments of sexual recidivism risk
  - But post-release outcomes found these judgments no better than chance
  - Scores on Scale 1 (Sexual Drive/ Preoccupation) significantly influenced ratings of risk for repeat sex offending
  - Of note, large amount of variance was unaccounted for, i.e., raters placed weight on factors external to J-SOAP-II

Outcome Studies

- J-SOAP II Total Score was not predictive of post-treatment offending
- Scale 2 significantly predicted any violent recidivism, not sexual recidivism alone
  - 3/8 Items: Conduct disorder before age 10, Juvenile antisocial behavior, and Multiple types of offenses.
- *Scale 3* predicted sexual recidivism (per scoring rules, Scale 4 was excluded)
  - 3/7 Items: Internal Motivation for Change, Remorse or Guilt and Cognitive Distortions

(Caldwell et al., 2008)

Summary

- Inconsistent support for J-SOAP II's predictive validity
- Methodological challenges (e.g., small samples, treatment involvement, low base rate of reoffending)
- Some studies found dynamic scales out performed static scales
- Scales varied in predictive efficacy, if any
- Sample dependent findings

JSOAP: some final thoughts

- Scale II may be more predictive of rape and general criminality. Recidivists may be quicker to recidivate compared to sexual disorders.
- Scale I, particularly with a male child victim may be more indicative of an emerging sexual disorder, although further assessment and inquiry will be necessary. Sexual arousal is dynamic.

JSOAP: some final thoughts

- Scales I and II are more related to risk and need (static factors)
- Scales III and IV more related to responsivity and treatment need
- The JSOAP is not a stand-alone, but can guide further inquiry

ERASOR (Version 2.0, February, 2001)

- 25-Item structured assessment guide
  - Items not intended for use without review of item description
  - Derived empirically, not actuarially
  - Currently in development
  - Available only from authors

Contact James Worling at jworling@ican.net

Defined

- "The ERASOR is designed to assist evaluators to estimate the risk of a sexual re-offense ONLY for individuals aged 12-18 who have previously committed a sexual assault".

ERASOR properties

- Reliability
  - Morton (2003) found significant Intraclass Correlation Coefficients for 23 of 25 items. This included total score & clinical judgment
  - Skowron (2004) ICC scored at a clinic with extensive files = .87. Percentage of agreement on 23 of 25 factors.
  - Rajlic & Gretton (2010) ICC's of .78 for clinical risk ratings and .89 for total score
  - Worling et al (2010) CJ=.87; total = .88

ERASOR properties

- "Recent escalation of negative affect" and "diverse sexual behaviors" appear to be more problematic for rater agreement

ERASOR properties

- Predictive validity (AUC)
  - Morton (2003) N=78 over 68 months; PV not predictive of sexual recidivism, although it did predict violence including sexual re-offense at .65
  - Skowron N=110 over 47.3 months; AUC = .71
  - Worling (2004) N=136; AUC for overall clinical = .66 and total score = .72

ERASOR properties

- Predictive validity (AUC)
  - McCoy (2007) N=128 with archival data, AUC=.50
  - Viljoen et al (2009) N=193 over 7.2 years; AUC = .64 (moderate PV)
  - Rajlic & Gretton (2010) N=268 over 6.5 years; archival material; AUC=.67 for clinical judgment and .71 for total score

ERASOR properties

- Predictive validity (AUC)
- Worling, Bookalam, & Littlejohn (in press)
- 22 clinicians in 5 agencies immediately after comprehensive evaluations. N=191 over 3.6 years.
  - Clinical judgment = .61 (not significant)
  - Total score = .72
  - Sum of "present" factors = .73

Not included

- "Commonly cited risk factors not *currently* supported by the research"
  - Denial of the sexual offense
  - Lack of victim empathy
  - History of nonsexual crimes
  - Offender's own history of child sexual abuse
  - Penetrative sexual assaults

ERASOR

- Deviant sexual interests
- Obsessive sexual interests / Preoccupation with sexual thoughts
- Attitudes supportive of sexual offending
- Unwillingness to alter deviant sexual interests/attitudes
- Ever sexually assaulted 2 or more victims
- Ever sexually assaulted same victim 2 or more times
- Ever sexually assaulted a child (<13; 4 years difference)
- Ever sexually assaulted a stranger
- Indiscriminate choice of victims

ERASOR

- Ever sexually assaulted a male victim (male offenders only)
- Diverse sexual assault behaviors
- Antisocial interpersonal orientation
- Lack of intimate peer relationships/social isolation
- Negative peer associations and influences
- Interpersonal aggression
- Recent escalation in anger or negative affect
- Poor self-regulation of affect and behavior (impulsivity)
- High-stress family environment

ERASOR

- Problematic parent-offender relationships / Parental rejection
- Parents not supporting sexual-offense-specific assessment/treatment
- Environment supporting opportunities to re-offend sexually
- No development or practice of realistic prevention plans/strategies
- Incomplete sexual-offense-specific treatment

ERASOR: Pros

- Excellent empirical basis
- Can aid in treatment, management plans
- Summarizes knowledge
- Has no hidden agenda (e.g. actuarial v clinical)
- Practical application of current research
  - Including what not to include
- Based on successful formulae
  - SVR-20, HCR-20, PCL, SARA, RSVP

JSORRAT-II

- Goals/Purposes of the JSORRAT-II, per authors
- Provide empirically based estimates of risk of juvenile sexual recidivism to inform a range of decisions, such as:
  - Placement
  - Programming
  - Treatment intensity
  - Resource allocation
- Reflected authors' belief that treatment outcomes must be defined and assessed with greater precision and specificity before good measures of modified risk can be developed

JSORRAT-II

- Developmental sample of 636 males in Utah
- Logistic regression analyses identified 12 variables that were optimally predictive of juvenile sexual recidivism

JSORRAT-II Reliability

- Reliability of Evaluators, per Epperson at ATSA 2009
- Collaborative study with Michelle Gourley and colleagues
- Seven state evaluators who had attended a one-day training session and scored the same 17 cases (stratified random selection) over the next couple of weeks
- Very high ICC for absolute agreement was .91

JSORRAT-II

Validation

- Completed for juvenile sexual recidivism in Utah and Iowa but not for adult recidivism
- Utah: N=494; AUC= .64
- Cases with complete data, AUC = .66

JSORRAT-II

Validation

- Georgia, N=318
- Base rate for juvenile sexual recidivism was
- 7.2%
- ROC-AUC = .65 (95% CI of .54 - .75)

JSORRAT-II

Per authors, Autumn 2009:

- JSORRAT-II has been successfully validated in two states
- Although the predictive validity was statistically significant in both studies, it was less accurate than in the development sample.
- May be used experimentally to tentatively advise treatment and programming decisions
- May be used to advise forensic decisions in Utah and Iowa, as well as in Georgia and California where the tool is being validated concurrently with use
- Assessments expire at age 18

Central Domains
(Based on Thornton)

- DYNAMIC RISK:
  - Sexual deviance
  - Contributory attitudes
  - Interpersonal functioning (Socio-affective)
  - Self-management
  - Influential others