Comprehensive Risk Assessment for Adolescents Who Have Offended Sexually:
With a Focus on the ERASOR (Estimate of Risk of Adolescent Sexual Offense Recidivism)
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Bill (age 19) Risk

- Sexually assaulted stepsister (2 years his junior)
- Denies sexual arousal to young children
- Denies sexual offenses
- No prior sexual assault charges
- Demonstrates no awareness of victim impact
- Has 1 prior conviction at age 15: possession of narcotics
- Repeated grade 3
- Long history of family violence
- History of cruelty to animals
- History of fireplay from age 9 to 11
- Will be living in detention centre for the next 18 months
- Significant depression

Samantha (age 13) Risk

- Sexually assaulted 1 female child; neighbour
- Minimizes offense
- Denies arousal to children
- Demonstrates some awareness of victim impact
- No prior charges; but delinquent behaviours (e.g. firesetting)
- Problematic family communication
- Marital conflict and numerous separations
- Will be living in a group home for the next 12 months
- No significant depression
- Several delinquent friends
- Childhood sexual victimization history

John (age 16) Risk

- Sexually assaulted 2 male children; strangers
- Acknowledges offenses
- Acknowledges some sexual arousal to younger children
- Demonstrates some awareness of victim impact
- 1 prior charge (at age 14) of sexually assaulting a young child
- No history of school difficulties
- No history of family violence or significant family conflict
- No prior nonsexual charges
- No close friends
- Living at home with no younger siblings
- Moderate depression

Risks

- Sexual Reoffence
- Nonsexual reoffence/offence
- Self-harm / suicide
- Victimization by others
- Placement breakdown
- School failure
- etc.

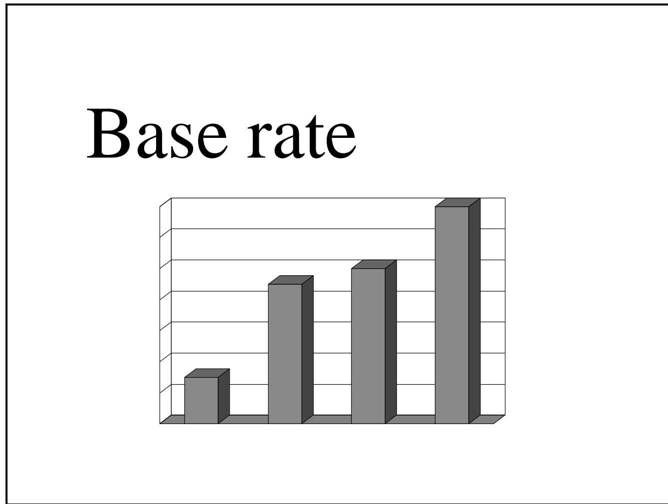
Potential perils of risk assessment

1. Potential for irreversible damage to adolescent
2. Lack of empirical evidence to make precise or definitive risk statements
3. May keep the focus on risks and deficits (rather than on strengths and protective factors)
4. Adolescence is a period of considerable change

Potential benefits of risk assessment

1. Matching client need and risk to treatment intensity/duration
2. Proper allocation of valuable treatment resources
3. Identification of specific risk factors to alter in treatment
4. Provides a common language among professionals

Prediction	Outcome: Reoffence	Outcome: No reoffence
Reoffence	True Positive	False Positive
No reoffence	False Negative	True Negative



Meta-Analysis of Treatment Effectiveness
Reitzel & Carbonell, 2006

- 9 studies (4 published; 5 unpublished)
- *n* = 2,986 (121 females)
- All studies had treatment vs. a comparison group
- Average follow-up = 58.6 months

Sexual Abuse: A Journal of Research & Treatment, 18, 401-421

Meta-Analysis of Treatment Effectiveness
Reitzel & Carbonell, 2006

Overall Recidivism (%)

Sexual	Nonsexual (violent)	Nonviolent	"other"
12.5	24.7	29	20.4

Sexual Recidivism (%)

Treatment	7.4
Comparison	18.9

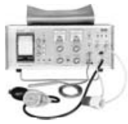
The 5 D's

1. Deviance
2. Delinquency
3. Disorder
4. Deficiency
5. Deceit

Risky and erroneous assumptions that have been made regarding adolescents who offend sexually.

Don't they *ALL* have deviant sexual arousal?

PPG Data



Seto, Lalumière, & Blanchard (2000)

25% - maximal sexual interest in prepubescent children

Seto, Murphy, Page, & Ennis (2003)

30% - responded equally or more to child stimuli

Therapist Ratings

Worling (2004)

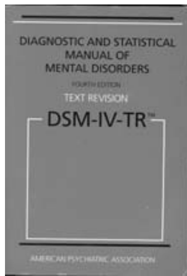
36% - rated as having deviant sexual interests

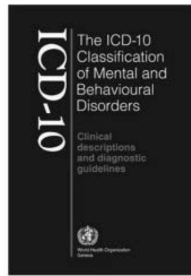
Aren't they all deviant?

Seto & Lalumière, in press, *Psychological Bulletin*

Nonsexual offences only	Sexual offences
↑ Criminal history	↑ Sexual abuse
↑ Antisocial peers	↑ Physical abuse
↑ Substance abuse	↑ Emotional abuse/neglect
	↑ Anxiety
	↑ Low self-esteem
	↑ Social isolation
	↑ Learning disabilities
	↑ Exposure to sex/pornography
	↑ Atypical sexual interests

Aren't they all delinquent?





Most adolescents who have offended sexually have the following clinical disorder:

None

Aren't they all disordered?

Strength-Based Approaches

Resiliency

Protective factors

Capacities

Skills

Positive gains

Hope

Aren't they all deficient?

Validity of Self-Report ?

- Laws, Hanson, Osborn, & Greenbaum (2000)

  self-report more accurate than PPG for identifying victim gender for adult males

- Day, Miner, Sturgeon, & Murphy (1989)

  self-report accurately classified men according to gender of their child victims

- Seto (2000)

  Most adolescents who acknowledged sexual interest in children showed deviance in PPG

- Worling (2006)

  Adolescents who reported sexual interest in children more likely to have child victims

Aren't they all deceitful?

Why do adolescents offend sexually?

Theory → Assessment → Treatment

It Depends

Personality-based typologies

3 different locations			
3 different decades	1980's	1990's	2000's
3 different measures	MMPI	CPI	MACI
	Smith et al.	Worling	Richardson et al.

1. **Overcontrolled, submissive, compliant**
2. **Delinquent, impulsive, unhappy**
3. **Isolated, insecure, unusual**
4. **Aggressive, self-indulgent, outgoing**
5. **Other**

Why Assess Adolescents Who Have Offended Sexually?

- Gain understanding of adolescent's unique strengths and needs
- Gain understanding of unique system strengths and needs
- Reoffense risk estimation
- Specific treatment recommendations
- Placement considerations/family reunification

Association for the Treatment of Sexual Abusers:
Practice Standards & Guidelines (2003)
www.atsa.com

The following are abbreviated excerpts regarding assessments:

- Cannot knowingly provide court testimony during the guilt phase of a criminal trial from which a reasonable person would draw inferences about guilt or innocence of a particular client

- There is ***<u>NO</u>*** known psychological/physiological test or profile that can prove or disprove whether an individual has committed a sexual offense

- Need to focus on client's risks, strengths, needs, and risk-management strategies

- Need to conduct a new assessment if there is not a recent (i.e., 12 months) one available

- Need to base assessment on factors such as client interviews, psychometric testing, review of official documents, and interviews with collateral informants such as family members—need to corroborate self-report with other sources where possible

- Need to keep evaluations of abusers and victims separate

- Need to take cultural background, socioeconomic status, gender, language, and physical and mental ability into account when conducting evaluations

- Need to produce objective and fair evaluation reports

- Need to clearly articulate treatment/supervision recommendations

- Need to conduct a comprehensive assessment that includes such factors as:
    - antisociality
    - developmental history
    - cognitive functioning
    - personality
    - sexual interests, fantasies, behaviors
    - sexual offenses
    - peer relationships
    - family relationships
    - access to sexualized media

Conducting Assessments with Adolescents Who Have Offended Sexually

1. Evaluators making decisions regarding an adolescent's placement or treatment should have the following: (1) a high level of training and expertise regarding the assessment of adolescents and their families, (2) a high level of training and expertise regarding the etiology, assessment, and management of sexual violence, and (3) familiarity with the existing research regarding adolescent sexual assault recidivism.

2. Evaluators should assess multiple domains of the adolescent's functioning, including sexual (e.g., sexual arousal, sexual attitudes, sexual preoccupation), intrapersonal (e.g., affective expression, impulsivity), interpersonal (e.g., social involvement, aggression), familial (e.g., parent-child relationships, family distress), and biological (e.g., neurological, physical health).

3. Evaluators should use multiple methods of data collection to form opinions regarding risk. Methods could include clinical interviews, psychological tests, behavioural observation, medical examinations, and reviews of previous case records and reports. At a minimum, evaluators should collect information directly from the offending adolescent AND from official records regarding the adolescent's sexual offense(s).

4. Evaluators should collect information from multiple sources such as the adolescent, the victim(s), the police, family, friends, and other mental health professionals who are familiar with the offending adolescent and his/her family. At a minimum, evaluators should collect information from the adolescent, adults responsible for the adolescent's care, and official records regarding the adolescent's sexual offense(s).

5. Evaluators should collect information regarding both static (historic and unchangeable) and dynamic (variable and potentially changeable) factors. Although research with adult sexual offenders has demonstrated that static factors are often the best predictors over lengthy time intervals, there is promise that a number of dynamic factors will be supported in future research (Hanson, 2000). Furthermore, information regarding dynamic factors will assist in treatment planning for those who will be assisting the offender to manage risk.

6. Evaluators should always be cognizant of the validity of the information that they are using in forming risk predictions and should state any reservations or qualifications in their reports. It may also be desirable for multiple evaluators to participate in the formulation of an estimate of risk—perhaps independently at first followed by a discussion of the findings.

7. Evaluators should recognize that risk assessments will become obsolete after the passage of time and/or following a change in ANY of the risk factors that were assessed.

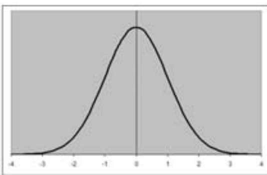
Unstructured Clinical

- Clinician choice of risk factors and method for determining if risk factors are present
- No link to a probabilistic reoffence estimate; final determination is clinical judgment

Empirically Guided / Structured Professional Judgment

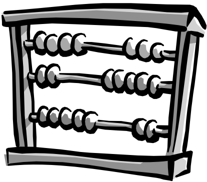
- List of established risk factors (often fixed)
- Structured coding rules for risk factors
- No link to a probabilistic reoffence estimate; final determination is clinical judgment

Norm Referenced



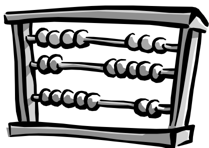
- Fixed List of established risk factors
- Structured coding rules for risk factors
- No link to a probabilistic reoffence estimate; final determination based on score relative to normative

Actuarial

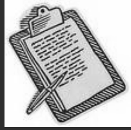


- Fixed list of established risk factors
- Structured coding rules for risk factors
- **MUST** be a link to a probabilistic estimate

Adjusted Actuarial



- Fixed list of established risk factors
- Structured coding rules for risk factors
- **MUST** be a link to a probabilistic estimate; **however**, adjusted based on clinical judgment



Can you answer all questions regarding risk?

- Is the youth at "No Risk" ?
- Does the youth fit the profile of a "sex offender"?
- What is the risk of a youth reoffending sexually through his/her adult years?
- What is your estimate of the risk that a youth poses of reoffending sexually over the next year?

"Other Factor"

To date, only used for about 5% of adolescents

Examples

- Emotional identification with younger children
- Current drug use
- Highly sexualized family environment
- Active psychosis

Common questions

1. What about female adolescents?
2. What about adolescents with impaired cognitive abilities?
3. What about adolescents who have noncontact offences (particularly child pornography possession)?
4. What about young adults who offended sexually as adolescents?

What to say about using the ERASOR with "special" populations?

For adolescents with significant cognitive limitations:

Most of the research and expert clinical guidance in the literature is based on work with adolescent males with borderline to average levels of cognitive functioning. There may be unique risk factors for those adolescents with below-average cognitive functioning, and/or the risk factors identified in the literature may operate differentially as a function of cognitive functioning. Unfortunately, there is no research regarding sexual reoffence risk assessment with adolescents who have below-average levels of cognitive functioning. Until such time that there is more direction from the literature, however, it seems reasonable to argue that many of the risk factors identified in the ERASOR would be applicable for those youth with below-average levels of cognitive functioning. For example, factors such as a sexual interest in prepubescent children, heightened impulsivity, interpersonal aggression, and a history of sexual assaults against strangers would most likely elevate the risk of a sexual reoffence, regardless of the level of cognitive functioning. Furthermore, there is emerging research with adults who offend sexually which indicates that risk assessment tools have some predictive utility across a wide range of levels of cognitive functioning. It must be stressed, however, that the validity of this risk assessment is limited by the lack of research specifically with adolescents with significant cognitive limitations, and the conclusions should be considered speculative.

For adolescent females:

Most of the research and expert clinical guidance in the literature is based on work with adolescent males. There may be unique risk factors for adolescent females, and/or the risk factors identified in the literature may operate differentially as a function of gender. Unfortunately, there is no research regarding sexual reoffence risk assessment with adolescent females. Until such time that there is more direction from the literature, however, it seems reasonable to argue that many of the risk factors identified in the ERASOR would be applicable for adolescent females. For example, factors such as a sexual interest in prepubescent children, heightened impulsivity, interpersonal aggression, and a history of sexual assaults against strangers would most likely elevate the risk of a sexual reoffence, regardless of gender. Furthermore, there is some research (e.g., with the Youth Level of Service/Case Management Inventory; Hoge & Andrews, 2002) which suggests that many risk factors for adolescent criminal recidivism are similar for male and female adolescents. It must be stressed, however, that the validity of this risk assessment is limited by the lack of research specifically with adolescent females, and the conclusions should be considered speculative.

Worling, 2009

Suggestions For Interpreting Overall Risk Ratings

Worling, 2007

The results of a recent meta-analysis (Reitzel & Carbonell, 2006) indicate that approximately 19% of adolescents who did ***not*** receive specialized, sexual-offense-specific treatment were subsequently charged for a sexual reoffense after a period of about 5 years. In contrast, approximately 7% of adolescents who received sexual-offense-specific treatment were charged with a new sexual offense during this same time period. In addition to a careful review of relevant risk factors, it will important to be mindful of these base rates of officially detected recidivism when formulating and communicating the overall risk rating. Of course, information regarding local base rates would be extremely important to consider as well, if available.

As noted in the ERASOR manual, there is no scoring algorithm that is used to arrive at the overall risk rating; rather, this rating is a structured professional judgment based on the combination of risk factors that are present. There are also no numerical equivalents for the overall risk-rating categories. The following are offered as suggested interpretations of "Low", "Moderate", and "High" risk:

"Low risk"

Relative to other adolescents who have offended sexually, there is a low risk of a sexual reoffense within the next year. As such, there are likely minimal supervision requirements, and, if there is a need for sexual-offense-specific treatment, it is likely to be less intensive and/or fairly short-term. Of course, there may be differing supervision and treatment concerns related to issues other than the risk to reoffend sexually (e.g., substance abuse, traumatic distress, self-harm, general delinquency, etc.).

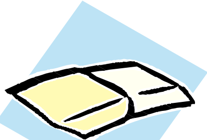
"Moderate risk"

Relative to other adolescents who have offended sexually, there is a moderate risk of a sexual reoffense within the next year. As such, there will be some supervision requirements, and there will be a need for sexual-offense-specific treatment. Of course, there may be differing supervision and treatment concerns related to issues other than the risk to reoffend sexually (e.g., substance abuse, traumatic distress, self-harm, general delinquency, etc.).

"High risk"

Relative to other adolescents who have offended sexually, there is a high risk of a sexual reoffense within the next year. As such, there are significant supervision requirements, and there is a need for sexual-offense-specific treatment—which is likely to be intensive and/or fairly long-term. Of course, there may be differing supervision and treatment concerns related to issues other than the risk to reoffend sexually (e.g., substance abuse, traumatic distress, self-harm, general delinquency, etc.).

Reitzel, L. R., & Carbonell, J. L. (2006). The effectiveness of sexual offender treatment for juveniles as measured by recidivism: A meta-analysis. *Sexual Abuse: A Journal of Research and Treatment, 18*, 401-421.



The "*ERASOR*"

(Version 2.0; Worling & Curwen, 2001)

Brief Overview of Research Support

October 2009

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SAFE-T Program, Thistletown Regional Centre
Ontario Ministry of Children & Youth Services
Toronto, Ontario, Canada

The Estimate of Risk of Adolescent Sexual Offense Recidivism (The ERASOR: Worling & Curwen, 2001) is an empirically-guided checklist to assist clinicians to estimate the short-term risk of a sexual reoffense for youth aged 12-18. The ERASOR was designed as a single-scale instrument, and the 25 risk factors that are evaluated fall under 5 headings: Sexual Interests, Attitudes, and Behaviors , Historical Sexual Assaults, Psychosocial Functioning, Family/Environmental Functioning, and Treatment. All risk factors are coded as either Present, Possibly/Partially Present, Not Present, or Unknown, and the coding manual outlines the specific coding criteria—in addition to the research/clinical support—for each factor. The manual and coding form for the ERASOR are available free of charge (as pdf documents) by sending an email request to the author at jworling@ican.net.

Presently, the ERASOR is in widespread use throughout Canada and the United States. It is also being used by clinicians in several other countries such as New Zealand, England, Scotland, Argentina, Sweden, Belgium, Germany, and Australia.

Research Support

There are presently a limited number of studies in which the ERASOR has been used. This is due primarily to the relative recency of the availability of the checklist and manual.

Reliability

In one investigation (Worling, 2004), 136 adolescents who had offended sexually were rated by 28 different Master's- and Doctoral-level clinicians following comprehensive assessments. Independent ratings from 2 different clinicians were available for 103 adolescents, and the interrater agreement (average rating intraclass correlation coefficient [ICC]) for the overall clinical rating (i.e., Low, Moderate, or High) was .92. Furthermore, interrater agreement (average rating ICC) for 19 of the 25 individual risk factors was ≥ .75. Given that the ERASOR was designed as a single-scale instrument, it should be pointed out that the internal consistency (Chronbach's alpha) estimate was found to be .75, and item-total correlations were at or above .25 for 21 of the 25 risk factors.

Edwards et al. (2005) used file information from 49 adolescents with a history of sexual offenses to determine factors predictive of treatment dropout. The authors used 7 ERASOR 2.0 risk factors in their investigation, and they presented inter-rater agreement for five ERASOR 2.0 factors. Kappa levels were "fair" (Attitudes supportive of
sexual offending; .44) to "excellent" (Interpersonal aggression; .79, Unwilling to alter deviant sexual interests/attitudes; .82, Impulsivity; .88, and Ever a male victim; 1.0).

Morton (2003) coded the ERASOR from the files for 78 adolescents who had offended sexually. Although some files had only demographic data from a previous research project (Worling & Curwen, 2000), several of the files were based on clinical assessments. From a subset of the files, significant ICC's were observed for 23 of the 25 ERASOR risk factors and for the overall clinical risk rating.

Skowron (2004) coded the ERASOR from extensive files at a clinic that conducts evaluations for the courts. ERASOR factors were coded in a binary fashion (present vs. not present) for 110 adolescents with a history of sexual offenses, and interrater agreement ratings for a subsample (average rating ICC) were noted as follows: Sexual interests attitudes and behaviors (.74); Historical sexual assaults (.78); Psychosocial functioning (.87); Family/Environmental functioning (.73); Treatment (.55). The interrater agreement (ICC) for the total score was .87, and percent agreement was above 80% for 23 of the 25 risk factors.

Hersant (2006) examined ERASOR data based on clinical assessments for 91 adolescents from 3 residential treatment programs. The estimate of internal consistency (Chronbach's alpha) for the 25 ERASOR items was found to be .87.

Viljoen, Elkovitch, Scalora, and Ullman (2009) coded the ERASOR for 193 male adolescents from extensive clinical files at a residential treatment program for adolescents who had offended sexually. Files were coded by doctoral students with training in risk assessment. Viljoen reported excellent interrater agreement (ICC) for both a Total score (.90) and for the overall clinical risk rating (.75).

Validity

Edwards et al. (2005) examined pretreatment data collected from files to predict treatment dropout for 49 adolescents who had offended sexually. Five of 7 ERASOR 2.0 factors studied significantly differentiated treatment dropouts from treatment completers: Attitudes supportive of sexual offending, Interpersonal aggression, Unwilling to alter deviant sexual interests/attitudes, Impulsivity, and Ever a male victim.

Skowron (2004) obtained recidivism data (criminal charges) from a nation-wide database over an average follow-up period of 47.3 months (*SD* = 41.1). Of the 110 adolescents with a history of sexual offenses, the recidivism rates were as follows: any reoffense (69%), nonsexual violent offense (17%), and sexual reoffense (35%). Using the area under the Receiver Operating Characteristic (ROC) curve (AUC), the ERASOR total score (based on binary coding of risk factors) was significantly predictive of any reoffense (.67), any nonsexual violent offense (.64), and any sexual reoffense (.71).

Morton (2003) coded the files of 78 adolescents who had participated in a previous investigation of the efficacy of treatment (Worling & Curwen, 2000). Although many of the files contained only basic demographic data, several of the participants had participated in comprehensive assessments as a result of sexual offenses. Recidivism data (criminal charges) were available from a nation-wide database over an average follow-up period of 68 months (*SD*=22.0), and the ERASOR was significantly predictive of violent (including sexual) reoffending (AUC=.65). Morton also reported that a modified score, based on 9 ERASOR items, was significantly predictive of sexual assault recidivism (AUC=.74).

Worling (2004) investigated the ERASOR's ability to discriminate those adolescents who had offended sexually and were detected for the first time ("nonrepeaters") from those

adolescents who offended sexually, were detected, and then reoffended sexually ("repeaters"). Based on clinical ratings completed by clinicians following comprehensive assessments, both the overall clinical rating of risk (AUC = .66) and an artificially created Total score (AUC = .72) were significantly predictive of repeater status. Furthermore, risk ratings were significantly higher for those adolescents in residential vs. community-based settings.

In a similar investigation, Hersant (2006) examined both Total scores and clinical risk ratings from the ERASOR for 91 adolescents following clinical assessments made at 3 residential treatment programs. It was found that both the Total score (Cohen's *d* = .59) and the risk ratings (High, Moderate, or Low; Cohen's *d* =.63) could significantly differentiate those adolescents known to have offended—been detected—then reoffended ("repeaters") from those who were being detected for the first time ("nonrepeaters"). Hersant also reported concurrent validity data linking personality constructs (such as impulsivity and egocentricity) to increased risk scores and ratings from the ERASOR.

Viljoen et al. (2009) examined recidivism data for 193 adolescent males who participated in residential treatment. ERASOR ratings were completed by a review of extensive clinical files, and the mean follow-up period was 7.2 years. Although several popular risk-assessment tools were examined (also see Viljoen et al., 2008), the clinical risk rating based on the ERASOR was the only score that was moderately predictive of risk of sexual recidivism (AUC = .64).

Bremer and Dellacecca (2006) examined ERASOR ratings made following comprehensive evaluations of adolescents with a history of sexual offenses: 141 from a specialized residential setting and 256 attending a community-based center in the same state. Adolescents in the residential centre were significantly more likely to have risk factors rated as "Present" for 22 of the 25 ERASOR factors. On average, those in residential treatment had 15 risk factors rated as Present; those in community-based treatment had 6 risk factors rated as Present.

In a similar investigation of adolescents who had offended sexually, Bourgon, Morton-Bourgon, and Madrigrano (2005) found significant differences for 9 ERASOR factors when they compared 29 adolescents in residential treatment to 86 adolescents from a variety of community-based programs. Using a subset of this sample (*n* = 53), these authors also used several of the ERASOR's dynamic, or potentially changeable, risk factors to track treatment impact over time.

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How to interpret an "**AUC**" value—area under the receiver operating characteristic (**ROC**) curve:

The probability that a randomly selected **recidivist** will have a higher score than a randomly selected **nonrecidivist.**

ranges from 0.5 (50% chance)
to to 1.0 (100% perfect)

AUC of .56-.63 "small" effect size
AUC of .64-.71 "moderate" effect size
AUC of >.71 "large" effect size

Hanson & Morton-Bourgon, 2009 *Psychological Assessment, 21*, 1-21

Meta-analysis of risk assessment accuracy

All actuarial tests

81 studies
24,089 males (primarily ADULT)
average **AUC=.68** (*d* =.67)

Static-99

63 studies
20,010 males (primarily ADULT)
average **AUC=.68** (*d* =.67)

J-SOAP-II Sexual recidivism

Martinez et al. (2007)
60 adolescents in community-based treatment
Retrospective file review-by treating clinicians
AUC = .78

Viljoen et al. (2008)
169 male youth in residential treatment
Retrospective file review
AUC = .54 ns

(example studies)

JSORRAT-II Sexual recidivism

Epperson et al. (2007)

494 juveniles aged 11-17 in Utah

Retrospective file review

AUC = .64

Epperson et al. (2009)

318 juveniles aged 11-17 in Iowa

Retrospective file review

AUC = .65

Meta-analysis of PROSPECTIVE validity of risk assessment instruments for juvenile justice

Craig S. Schwalbe

Law & Human Behavior (2007), 31: 449-462

28 studies

(53,405 juveniles; 28% female 55% white)

28 risk different assessment instruments

Follow-up from 6-60 months (12 months typical)

45% reoffended

Weighted average effect size AUC=.64 (SD=.042)

r = .25

Meta-analysis of PROSPECTIVE validity of risk assessment instruments for juvenile justice

Craig S. Schwalbe

Law & Human Behavior (2007), 31: 449-462

Weighted average effect size AUC=.64 (SD=.042)

No difference if published vs. unpublished data

No difference is file based vs. direct interview with youth

AUC=.66 for general probation; AUC=.62 for high risk youth

AUC=.68 if not cross validated; AUC=.64 if cross validated

Example Sexual Reoffence Risk Statement

There are currently no empirically validated, actuarial instruments that can be used to reliably pinpoint the risk of sexual reoffending for an adolescent. However, a number of high-risk factors for adolescent sexual reoffending have been identified through both research and a review of expert clinical opinion. The Estimate of Risk of Adolescent Sexual Offense Recidivism (The ERASOR: Worling & Curwen, 2001[1]) is a structured checklist of risk factors that is based on the available research and clinical expertise, and this checklist was used in the present assessment. It is important to stress, however, that the final estimate of risk is a clinical judgment. It should also be stressed that there was limited information in the file regarding the sexual offences beyond a brief police synopsis and this significantly limits the validity of the present assessment. Although Terry appeared to be quite open regarding the past sexual assaults, the shame, embarrassment, and fear of legal consequences typically connected with a sexual assault often results in the minimization of aspects of past offences such as the duration, frequency, intrusiveness, and the level of violence. As such, it will be important to reconsider an estimate of future risk if there is a disclosure of further details of the sexual offences.

At the present time, and based on the information available during this assessment, Terry currently presents a moderate degree of risk (i.e., not "high" and not "low") of reoffending sexually in the next 12 months. This determination is based on the presence, and combination, of a number of high-risk indicators including both static factors (historical and not changeable) and dynamic factors (recent and potentially changeable). With respect to the static risk factors, Terry has a history of sexual assaults against multiple victims and a past sexual assault against a stranger. For the dynamic, or potentially changeable risk factors, there is evidence that Terry presently exhibits an antisocial orientation with others, demonstrates a recent pattern of interpersonal aggression, is generally impulsive, and has a conflictual parent-child relationship. Additionally, Terry does not have formalized, offence-prevention plans and has not yet completed sexual-offence-specific treatment. It should be pointed out, on the other hand, that there are several high-risk factors that were not observed for Terry such as deviant sexual interests, attitudes supportive of sexual offending, social isolation, and high family stress.

There was no evidence to suggest that Terry's risk to others is imminent; however, Terry's own report suggests that the risk of a sexual reoffence is more imminent when there is access to sexualized media and when supervision in the community is relaxed. It is also likely that Terry's risk is more imminent when feelings of despair and hopelessness are present.

Given the rapid developmental changes during adolescence, the potential for change in a number of these risk factors, and the fact that much of the supporting research is based on follow-up data of less than 3 years, it is essential to note that this estimate of risk should be re-evaluated after a period of at most 1 year or following significant social, environmental, familial, sexual, affective, physical, or psychological change.

[1] Worling, J. R., & Curwen, T. (2001). Estimate of Risk of Adolescent Sexual Recidivism (The ERASOR: Version 2.0). In M. C. Calder, *Juveniles and children who sexually abuse: Frameworks for assessment* (pp. 372-397). Lyme Regis, Dorset, England: Russell House Publishing.

STABLE-2007
(Dynamic Risk Assessment for **ADULTS**)
Karl Hanson & Andrew Harris

Example factors:

- significant social influences (lack of positive)
- emotional identification with children
- deviant sexual interests
- sexual preoccupation
- lack of concern for others
- poor problem-solving skills

Andrew.Harris@PSEPC-SPPCC.gc.ca

Desirable Assessment Preconditions

1. Police investigation of sexual offending has been completed, and there is no outstanding court date regarding guilt or innocence

If not…

- Places you in the role of investigator and, potentially, witness
- Makes it difficult for youth and family to be open

Desirable Assessment Preconditions

2. Adolescent is living (**TEMPORARILY**) in a residence in which there are no individuals whom they abused and, ideally, no other vulnerable individuals (e.g., children under 12).

If not…

- Difficult to accurately assess risk
- Difficult to accurately assess other family members
- Potential current abuse will be missed

Desirable Assessment Preconditions

3. You are in possession of official documentation (police, child welfare) regarding past sexual offending and other past involvement of police or child welfare.

If not…

- You are dependent on adolescent's account of past sexual offending (and other past systems involvement) and there may be information missing

Setting the Stage For the Interview

1. Read the background information
2. Ensure you have a good physical space—chairs; coffee table; writing materials; reduced visual, tactile, and auditory distractions
3. Be sensitive to client's likely shame, embarrassment, and anxiety

Informed Consent

- the assessment process (interviewing, testing, document review, informant interview)
- time requirements
- nature of the questions
- specific agency expectations, rules, etc.
- access to, and storage of, information
- limits of confidentiality
- possible risks / benefits
- possible alternatives
- assessment report and feedback

Interviewing Adolescents Who Have Offended Sexually: Worling, 2000

- **Be aware of your own comfort level in talking about sexual issues**
- **Make predictions regarding defenses; i.e., normalize discomfort**
- **If you are asking about something that is potentially embarrassing or negative, assume that there is more**
- **If you are asking about something that is "normally" expected, assume that there is none**
- **Watch for "Did you…, Do you ever…, Have you…, Are you…, Can you remember a time when…" questions**
- **Sit at 90 degrees from the adolescent; not across**
- **Be careful not to supply the answer**
- **Interview the client; try not to engage in interventions**
- **Be careful to get the right amount of information to answer your question**
- **Use concrete materials (family trees, maps, floor plans, time lines, pictures, charts, etc.)**
- ***Any confrontation should come from a position of caring and should be respectful***

School issues:
• current performance
• past performance
• peer interaction
• teacher interaction
• extracurricular involvement
• special programs, if any
• number of changes in schools and why
• most/least favourite subjects

Social/Recreational:
• best friend
• contact with friends (frequency and nature)
• number and gender of friends
• interpersonal intimacy with friends
• loneliness • age of friends
• supports for emotional issues
• boundaries with friends
• favourite pastimes, hobbies, habits, sports
• teasing (receiving)
Who is your best friend?
How old is s/he?
What is their last name?
How often do you get together/speak on the phone?
What kind of things do you do together?
What kind of things would you not be able to talk about with them?
When did you last seen them?
How many *really* close friends would you say that you have—people you can talk to about almost anything?
What do you do together? How often? Who initiates the activities?
Whom have you told about your sexual offense(s)?
Most kids are teased when they are younger and kids can be kind of mean; what did kids used to tease you about? (Currently? How did/do you feel? What do you do with your feelings of --- ?)
On a scale from 1 to 10, with 1 being "low" and 10 being "high", how lonely are you now?
When you are feeling lonely, what helps you to feel better?
What are your favourite things to do if you have a free Saturday afternoon?

What teams, clubs, groups do you belong to? Past?
How many hours a day, on average, do you spend watching TV? What are your favorite TV shows? Movies?
How many hours a day, on average, do you play video games? Favorites?
How may hours a day, on average, do you surf the Internet? Favorite sites?
Reading? Favorites?

Nonsexual Delinquency:

• history of fights • firesetting
• cruelty to animals • gang involvement
• cruelty (verbal & physical) to siblings and other children
• empathy for recipients of aggression, theft, etc.
• nonsexual offenses (shoplifting, theft, weapons, etc)
• first contact with police
• prior criminal charges/convictions
• substance use/abuse • truancy
• family reaction to aggression and delinquency

How old were you when you first got in trouble with the police?
How old were you when you first played with matches or lighters? How many fires have you set?
How often did you set the fires on your own? With peers? How do you think it affected others?
How old were you the very first time that you shoplifted? How many times a week …? What did you usually take? How often were you caught? Reaction of others? How did it affect others?
How old were you when you first tried alcohol? How many times a week? Currently?
Parents' reaction? (same with drugs, and "Which drugs?)

Emotional Expression (nonsexual):

• affective expression and control (overcontrolled? undercontrolled?)
• depression • loneliness
• anger • grief
• happiness • rejection
What kind of things make you most angry?
What do you do with your anger in these situations?
How does your mother react? Father? Others?
How do others know when you're angry
What is your saddest memory?
What kind of things make you sad?
How do others know when you're sad?
What do you do to make yourself feel better?
What is your happiest memory? Why?
How old were you the first time someone close passed away? How did you cope?

Self-esteem:

What do you like best about yourself?
What are you most proud of in your life?
What do you like least about yourself?
If you had a magic wand, what changes would you make to yourself?

Sexual Development:

• puberty/development • family sexual boundaries
• sex education • early sexual experiences
• sexual orientation •pornography/sexual media
• consensual sexual experiences • fetishes

How old were you when you first noticed your body beginning to develop? Who did you talk to about the changes? When did the changes end?
How old were you the first time that you looked at a magazine with sexy pictures/stories? Movie?
How many times a day do you look at them now? Then? How did you get them? What kind of sex was shown (and ages of the people depicted)?
How old were you when you first tried a phone sex line?
How many hours a day do you spend on the Internet?
How old were you the first time that you saw a sexy website on the Internet?

Every family is different—some families have strict rules about nudity and changing and showering, others don't—what about your family?

Your probably a bit young to have had a girlfriend/boyfriend yet, right? (If not, then How old were you the first time that you had a girlfriend/boyfriend? Last time? How long do your relationships last? Who usually ends the relationship? Why? What kinds of things did you do together? What kind of sexual things? What do you look for in a girlfriend/boyfriend?). (If right, then, How old do you think you will be when you start dating? What are the things that make it hard for you right now to date?).

Masturbation:

• age of onset • attitudes • 1st experience
• frequency • deviant fantasy • fantasies
• fused sex & violence • family/culture issues

If we had a hundred girls/guys aged – come into this room one at a time and they had to tell the truth, how many of those hundred girls/guys would say that they masturbate regularly—remember, pretend that they would have to tell the truth?
What do you think about masturbation, is it something that's acceptable? Why? What do your parents think?
How old were you when you started masturbating?
How many times a day do you masturbate?
Of those --- times in a week, how many times are you thinking about__________
• girls under 12 • boys under 12 • teenage girls
• teenage boys • adult women • adult men
• your victim(s) • being rough with a person

How old were you the first time that you saw a pop-up on the internet that showed a naked person of someone doing something sexual? How many hours a day do you look at sexual websites? What kind of websites (pictures, movies, adults, teens, children, etc, etc.) Sexual chatrooms? How old were you the first time you saw a magazine with sexual pictures? How many times a day do you look at them? What are the pictures of? How many magazines do you own? Where did you usually see them?
Most people talk about a typical thought or fantasy that they masturbate to—what do you usually think about?

Amenability to Treatment:

• previous treatment • motivation
• self-risk rating • trial exercises (chain) • supports
• family involvement • prevention techniques
• theory of offending

Sexual Victimization:

• trauma • disclosure • cognitions
• physiology • response of others • affect
• nature of abuse • relation to offender(s)
• violence
How old were you the first time that someone touched you in a sexual way?

Sexual Offense:

• fantasy • grooming behaviours
• planning • affect
• victim impact awareness
• violence • duration
• frequency • coercion/threats
• disclosure • relation to victim(s)
• ritualism • age began offending
• specific sex behaviours • progression
• voyeurism • exhibitionism • bestiality
• sexual sadism • sexual masochism • obscene calls
How many times a day did you offend?
Over how many years?
How many days in advance did you typically plan the offense?
Why did you pick ------ to offend against?
How did you choose that place? That time?
What was your escape/cover plan?
How did you get ------ to keep the offenses secret?
How did you get ------ to go along with you?
How did the police eventually find out?
How do you think ----- was feeling during the offense?
How do you think your offense will affect ---- in the future?
What did you say to ------ get him/her to keep the sexual assault secret?
A lot of teens who have committed sexual offenses did not just begin by…they began by exposing themselves or peeping in windows or washrooms—how old were you when you first tried to look at a person getting changed through a window or in a washroom? Showing your private parts?
About how many times have you called up a stranger and made sexual comments? Other prank calls?
How did the offenses start? (looking for progression)
How did the victim try to resist? What did you do?

Denial:

• denial of any interaction •denial interaction was sexual
• denial interaction was offense

Minimization:

• Of responsibility • Victim blame
•External attributions • victim education
• Irresponsible internal attributions
• Of extent • Frequency
• Number of victims • Force used
• Intrusiveness • Of harm
• no long-term effects
[from: Barbaree, H.E., & Cortoni, F.A. (1993).
On a scale from 1 to 10, with 1 being really low and 10 being really high, if you think really hard and are really honest, where would you rate your risk of committing a sexual offense against___________(use appropriate categories)
Why?
Some people tell us that there were lots of

times that they were about to offend but stopped themselves before an offense happened—how many close calls have you had in the past 2 years? How were you able to stop yourself?
Who in your family would be the most helpful to you to work on learning and practicing strategies to prevent further offenses? Why? Least helpful? Why?
What changes do you think that you need to make to make your risk go down to a "1"?
If you could change anything about yourself, what kinds of changes would you make? Your family?
When you really think about your offenses, what is your theory right now about why you committed the sexual offenses?

Sexual Attitudes:
• towards sexual interactions with children
• towards forced sex with peers/adults
• family attitudes

Non-offensive Sexual Relationships:
• sexual involvement • consent
• partner attributes • apprehension
• intimacy • future plans
How old were you when you first had a

girl/boyfriend?

How many girl/boyfriends have you had?
How long do you usually go out with them?
What kind of things do you do together?
How did the relationship end? How did you feel?
What do you look for in a girl/boyfriend?
How old were you the first time that you touched a partner in a sexual way?
How did you know it was OK with her? In general, how does someone know when it is OK to touch a girl/boy in a sexual way? How do you tell?
What kind of things can you talk to your girl/boyfriend about? Not talk about?

***Family Issues*:**
• openness • affective expression
• conflict resolution • power
• behaviour control • empathy
• trust • respect
• intimacy • roles
• marital issues • attachment
• adaptation • impact of offenses
• alliances • privacy
• sexual attitudes• parent sexual behaviours
• sexual media •"sexualized" relations
• sexual communication

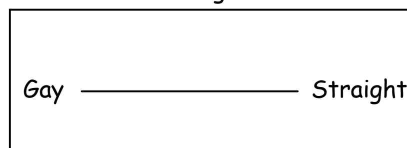
•histories of offending / victimization

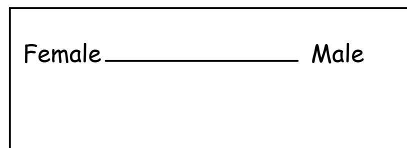
• denial/minimization • supports

• culture/religion• treatment motivation

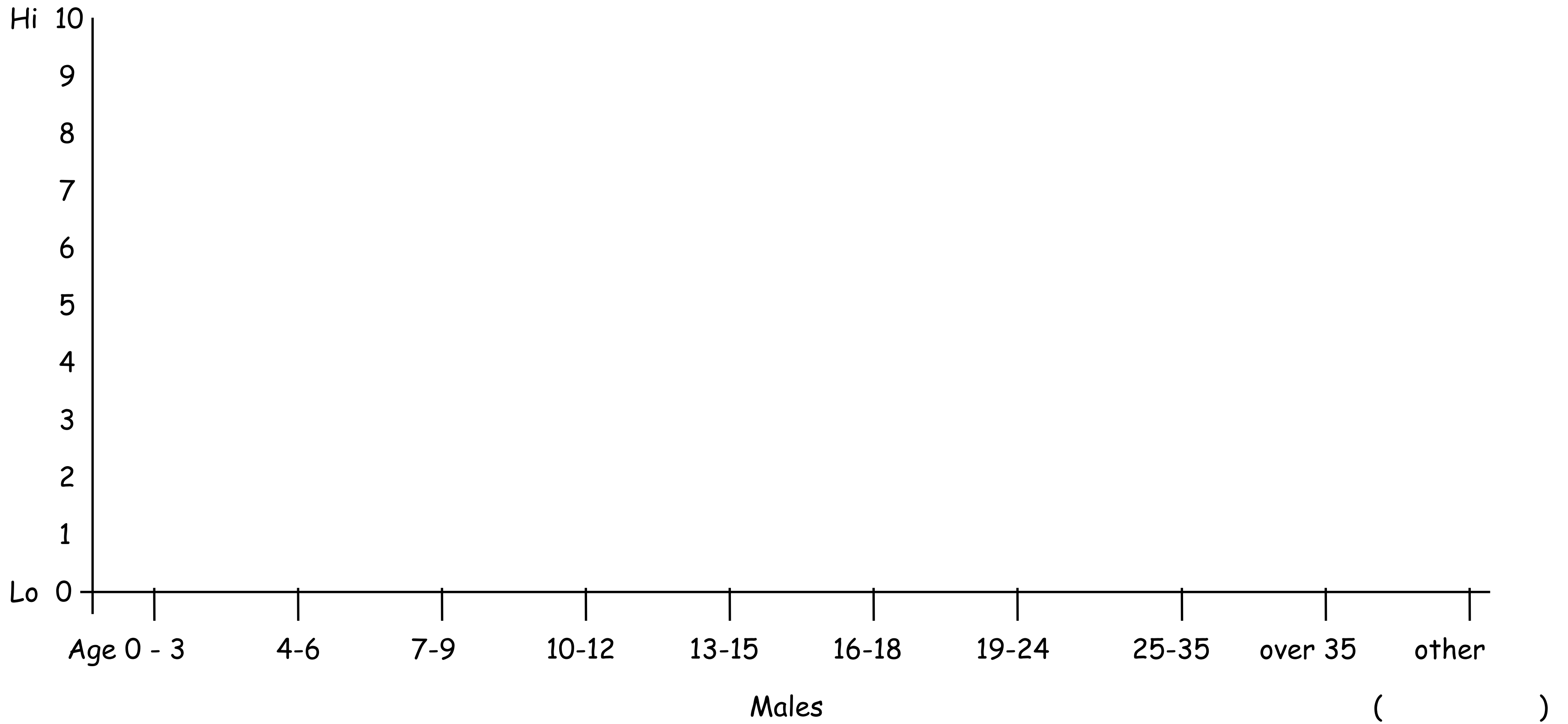
Who are you closest to in your family? Why? Who next?
Who was most affected by the sexual assaults?
Who sets the rules in your family?
How old were you the last time a parent used physical discipline?
How old were you the first time you accidentally saw someone changing or engaged in sex at your home?
How old were you the first time you found pornography at your house? What kind of images were they? How did your parents react?
Tell me about how your parents get along.
How important is religion in your life? For your family?

Other tools helpful in the interview:
• interviewer draws a genogram while discussing family issues
• interviewer draws a timeline while discussing significant changes and events (moves, parental separations, offenses, awards, favourite memories, etc.)
• adolescent draws a map/floorplan of the home/location of the offenses and adds detail as offenses are being discussed





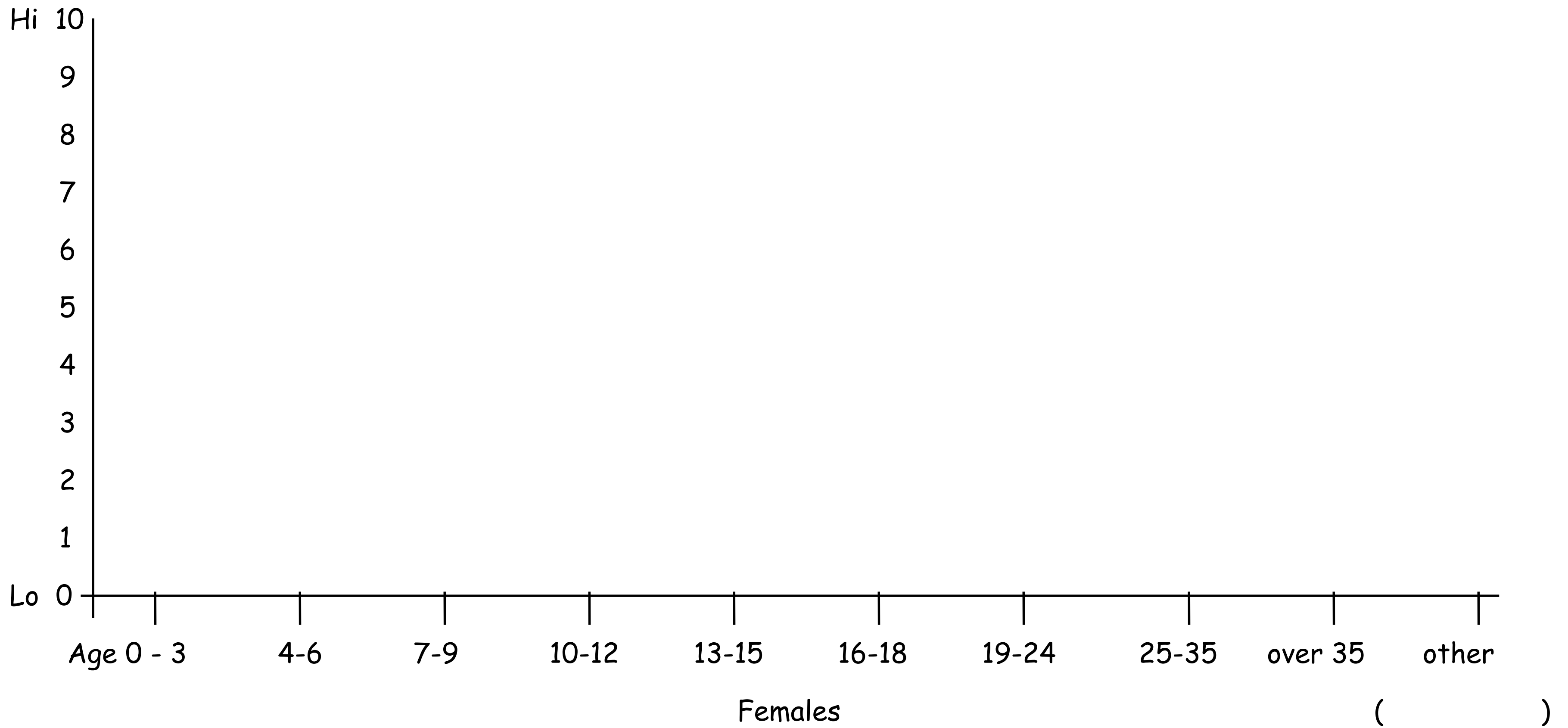
Everybody is different. Where would you put yourself on this line today with respect to wondering if you are gay or straight? What's the furthest this way you have been? This way? Where do you want to end up when you are 20? (same for female-male)



Name:_______________________________________ No Force ☐

Date:_______________________ Force ☐

Copyright © Worling, 1998, 2003



Name:_______________________________________ No Force ☐

Date:_______________________ Force ☐

Copyright © Worling, 1998, 2003

Sexual Arousal Graphs (Worling, 1998, 2003): Instructions

Paper & pencil sexual arousal assessment (1 graph for males and 1 graph for females: scale from 0 to 10 on Y axis: various age categories on X axis).

(while sitting at a table at 90 degrees from the adolescent, place the first graph in front of the adolescent—start with the graph [male or female] that is the same gender as the adolescent. That is, for male adolescents start with the "Male" graph)

"This is a special graph to help us look at the kinds of things that you would find sexually arousing; that is, things that would turn you on sexually. Everyone is different regarding what kinds of things turn them on and turn them off, and it is important to go through this slowly. It is also really important that you are as honest as possible."

(point to the first graph) "You see that this graph has a scale from 0 to 10. Zero means that you would not be sexually aroused at all—that you would not find a person in that category sexually attractive at all. You might even think that it would be gross or disgusting. A ten means that you would be really sexually aroused or turned on sexually. A five would mean that you would be somewhat turned on sexually, and so on. Down on the bottom are males [females] of different age groups. Now the first group of ratings we are going to make are ratings of how turned on you would be doing sexual things with males [females] without the use of force—i.e., not pushing, or hitting, and no other violence; just doing sexual things and the person would go along with you."

(hand them a multi-color pen—you could also just have available several different colors of pens/pencils) "Take this pen and choose a color and colour in this box here that says 'No Force' because this will be the legend for our graph". (**interviewee takes pen** and colours in the "No Force" legend with the coloured pen). "Now, with that same colour, show me by putting a mark on this graph how sexually aroused you would be doing sexual things with a male aged 0-3, so that would be boys who are newborn, and 1, 2, and 3 years old. Remember, everyone is different regarding what kinds of people turn them on. Now, what about your sexual arousal to males aged 4-6?" Continue through the age groups slowly. When it comes to the "other" category, this is when one can ask about arousal to family members or other specific sexual targets that you want to question (e.g., animals).

"Now, choose a different color and color in the 'Force' box. Now we are going to rate how sexually turned on or aroused you would be if you used force to do sexual things with people. By 'force', I mean holding someone down or hitting them and making them do sexual things when they don't want to. Everyone is different, and some people are more sexually turned on when they think of using force and some people are more turned off. For others it doesn't really change how turned on they would be. How does the use of force change how sexually turned on you would be doing sexual things with a male aged 0 to 3?" Then proceed through other age groups.

This whole procedure is then repeated with the graph for the second gender. When both gender graphs are done, if an adolescent rates their victim's age and gender grouping as a "0", you could gently challenge them ("Are you sure about this rating, your brother was 8 years old when you were offending against him, and the other boy was 7?"). You can also use another colour in these circumstances and ask to make an additional box in the legend that says "At the time of the offense" and then, with a third colour, ask the adolescent to describe their sexual arousal patterns at the time of the offenses. Indeed, some adolescents spontaneously ask "Do you mean how I would rate these now or at the time of the sexual offenses?" This can then lead into discussions about how and when the arousal patterns have changed.

Assessment Report: Focus on Issues Related To Sexual Offending

Client information (name; birthdate; age at assessment)

Referral Information

Source and date of referral; referral question(s); intended recipient(s) of report; legal status of adolescent

Sources of Information

Dates (and durations) of interviews with all individuals, specific tests and measures used for all individuals, specific reports reviewed—including report dates, titles, and authors

Limitations of Report

Express any and all concerns regarding limitations of your findings (e.g. questionable validity of specific data gathered, lack of official documentation, lack of specific interview and, of course, the resulting impact on the results)

General Approach to Assessment

Client's overall presentation (initial presentation; honesty; cooperation) and attitude towards assessment; level of candidness on psychological tests and questionnaires; family members' presentation and participation

Family History/Family Functioning

Developmental history; Past, present, and future family relationships; communication; intimacy; family rules and discipline (including emotional/physical abuse experiences); parental reactions to offending; family motivation to engage in assessment/treatment

Placement/Treatment History

Chronology of interventions; response to interventions; reasons for changes (or lack thereof).

Intellectual, Academic, Cognitive Functioning

Cognitive functioning (strengths and concerns); academic strengths and concerns; school issues; thought and attentional difficulties

Social/Recreational Functioning

Interpersonal intimacy; friendships; social skills; interpersonal orientation; social involvement; hobbies; interests; sports.

Emotional Functioning and Expression

Affective expression, control, and coping strategies (both negative and positive affect); recent increases/decreases in affect

Spirituality

Connection to people and the world; formal religious involvement; important beliefs

Potentially Traumatic Experiences / Posttraumatic Distress

Sexual, physical, emotional victimization; witnessing violence; loss; accident; storm; intrusive and scary medical procedure; removal from the home; war; indicators of posttraumatic distress (e.g., re-experiencing trauma, increased arousal, emotional numbing, etc.)

Nonsexual Delinquency

Nonsexual criminal offenses; procriminal / prosocial attitudes; history of cruelty and aggression; substance use/abuse; prosocial / antisocial interpersonal orientation

Employment/Future Plans

Past employment; plans for future employment and study

Physical Health

Medical history; present physical concerns and needs

Self-Perception

Self-esteem; self-perceived strengths, concerns, and goals

Sexual Development

Puberty; history of nonoffensive sexual behaviours; masturbation onset; past and present use of sexualized media (text, pictures, internet, movies, etc.)

Sexual Attitudes

Attitudes towards sexual offending (e.g., towards sexual violence; towards sexual interactions with children); attitudes towards romantic relationships; attitudes towards gender roles

Sexual Arousal/Interests

Past and present sexual arousal and interests; sexual orientation; current strategies to express/control urges and fantasies; degree of sexual preoccupation; current masturbatory thoughts and behaviors

Sexual Offending

Sexual offense(s) details including frequency, duration, locations, level of force, grooming behaviors, victim selection, assault behaviors ; difference between adolescent's description of events and that provided in official documentation; understanding of victim impact; compassion for victim(s); amenability to offense-specific treatment; understanding of consent issues; motivation to change; awareness of personal risk factors

Parental / Staff Perceptions of Strengths

Adult perceptions of client's strengths

Summary

- Reiteration of limitations of the assessment
- Strengths (individual, familial, systems)
- Risks (sexual reoffense, nonsexual criminal reoffense, self-harm, substance abuse, victimization by others, school failure, placement breakdown, etc.)
- Recommendations

  Specific treatment, supervision, and case-management recommendations related to concerns noted in the assessment; need for further assessment (e.g., speech-language, medical, recreational, or assessment to address area missed in the present assessment), and the need for, and timing of, a re-assessment

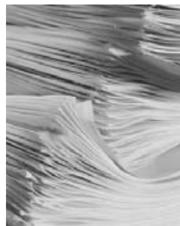
Name(s) and signature(s) of evaluator(s) and date of report

Parent Interview(s)

- youth's developmental history
- family rules, boundaries, expectations
- family communication patterns/styles
- disclosure reaction(s)
- view of youth's sexual offending
- youth's past/current functioning (social, cognitive, familial, sexual, etc.)

Parent Interview(s)

Be **very careful** when collecting and documenting personal health information regarding the parents and other family members—particularly when the "client" is the youth and/or the court.



Document Review

- official documentation of sexual offending
- past/current reports from child protection and probation
- school reports
- prior assessment reports
- treatment summaries / case notes from prior treatment
- other letters/reports on file

Denial & Minimization

Remember…

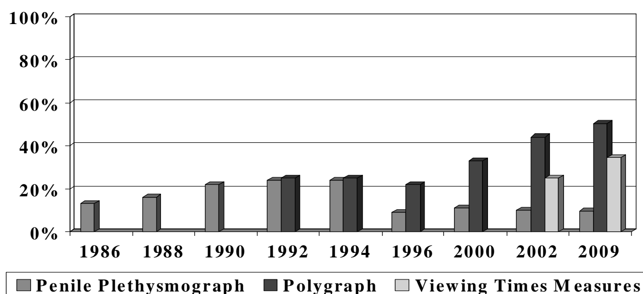
1. Shame and embarrassment are natural
2. Parents are often naturally in shock & disbelief
3. Aggressive confrontation is harmful and counterproductive
4. "Denial" is not predictive of future risk
5. There is no research that supports the notion that "full" disclosure of details leads to successful outcome

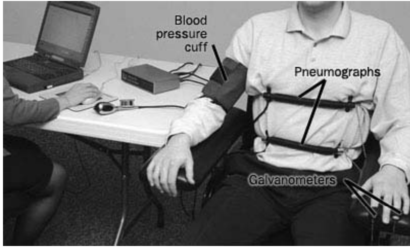
What would be the worst thing that could happen if you went home today and said, "I really did commit the sexual offense(s)"?

How likely is it that you really did commit a sexual offense? (1 to 10 scale) or, What's the percentage likelihood that you really did commit the sexual offense(s)?

Psychophysiological Assessment Methods
U. S. Community Programs for Adolescents

McGrath, Cumming, Burchard, Zeoli & Ellerby (2009). Safer Society Survey.



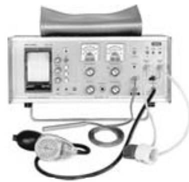


The Polygraph and Lie Detection: Committee to Review the Scientific Evidence on the Polygraph

Washington, DC: NATIONAL RESEARCH COUNCIL OF THE NATIONAL ACADEMIES

(2003)

Reliability?



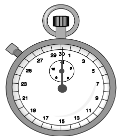
- poor-to-fair test-retest reliability of PPG with adolescents

Validity?

- Most adolescents who denied their sexual offenses also provided invalid PPG arousal data (Becker et al., 1992)
- PPG deviance index for adolescents inversely correlated with age (Kaemingk et al., 1995)
- PPG deviance index for adolescents correlated with history of physical and sexual abuse (Becker et al., 1989; 1992)
- PPG deviance index NOT predictive of sexual assault recidivism for adolescents (Gretton et al., 2001; 2005)

Penile plethysmograph

Unobtrusively measured viewing time



Abel, Jordan, Rouleau, Emerick, Whitehead, & Osborn, 2004

Sexual Abuse: A Journal of Research & Treatment, 16, 255-265

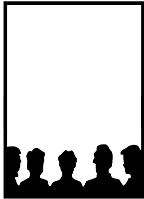
Abel Assessment for sexual interest ™

(unobtrusively measured viewing time)

Adolescents with a child victim	n = 1,170
Adolescents with peer/adult victims	n = 534

Correlation of VT to children with # of victims	.21
Correlation of VT to children with # of acts	.21
Discrimination of groups by VT to children	AUC=.64

Participants



- 78 males aged 12-18 (mean = 15.09; *sd* = 1.62)
  - 44 from residential treatment in Minnesota
  - 34 from community-based programs in Greater Toronto Area
- 67% offended against at least one child (4 or more years younger AND under 12)
- No adolescents who denied offence volunteered to participate

AFFINITY System (Glasgow)

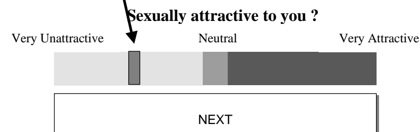
Worling, J. R. (2006). Assessing sexual arousal for adolescents who have offended sexually: Self-report and unobtrusively measured viewing time. *Sexual Abuse: A Journal of Research and Treatment, 18*, 383-400.

1. Affinity self-report

(scale from 0 – 18)

2. Affinity on-task latency (in seconds)

Time taken to rate photo



AUCs

Discriminant Validity

	Affinity OTL	Affinity Self-Report	Self-Report Graphs
Ever a child victim	.61	.67*	.66 *
2 or more child victims	.60	.73**	.70**
Ever a male child victim	.69**	.72**	.72**
Only male child victim(s)	.73**	.74**	.76**
Ever a female child victim	.42	.48	.45
Only female child victim(s)	.43	.42	.41

Psychological Tests and Questionnaires: CURRENT Personal Favourites

Formally Published; Norm Referenced

- Child Behavior Checklist (CBCL; Achenbach, 2001)
  Parent, Youth, & Teacher Report Form
- Wechsler Intelligence Scale for Children—Fourth Edition (WISC-IV; 2003, or Wechsler Abbreviated Scale of Intelligence)
- Millon Adolescent Clinical Inventory (MACI; Millon, 1993)
- Reynolds Adolescent Depression Scale—2nd Edition (RADS-2; Reynolds, 2002)
- Multidimensional Anxiety Scale for Children (MASC; March, 1997)
- Trauma Symptom Checklist for Children (TSCC; Briere, 1996)
- Behavioral and Emotional Rating Scale—2nd Edition (BEHRS; Epstein 2004)

Experimental Measures*—current favourites*

- Attitudes Towards Sex with Children (items from Hanson's "Sexy Children" scale and adapted by Worling for teens)
- UCLA PTSD Index for Adolescents (parent and self-report; Pynoos & Rodriguez, 1998)
- Adolescent Clinical Sexual Behavior Inventory (parent and self-report; Friedrich, 2004)
- SAFE-T Sexual Offense Questionnaire (Worling, 1999)
- Identification With Younger Children Scale (parent and self-report; Worling, 2006)
- Sexual Offending Guilt, Shame, and Resiliency Questionnaire (parent and self-report; Worling, 2007)

Given the shame, guilt, and embarrassment typically associated with sexual offending—and the potential negative legal, familial, and social consequences—it is not uncommon for adolescents to minimize aspects of their past sexual offending and/or their current sexual thoughts, feelings, and behaviours.

Report writing concerns:

- certainty (e.g., "no risk")
- singularity regarding offending (e.g.,"the incident")
- excess use of jargon
- excess use of abbreviations
- excess use of "canned" test interpretation
- few and/or vague recommendations
- risks and deficits only (no strengths)
- incongruous level of detail (too much or too little)
- poor grammar, punctuation, and spelling

Building Opportunities for Health

Assist youth to establish and maintain…

- **a positive support network**
- **prosocial hobbies, interests, and other activities**
- **positive family relationships**
- **positive peer relationships**
- **positive affective coping skills**
- **positive sexual knowledge, attitudes, interests, and behaviors**

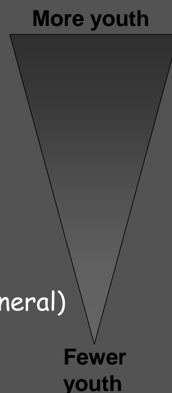
Assist youth to establish and achieve realistic future goals

Placement decisions should be based on:

1. UNIQUE risks, strengths, and needs related to sexual offending—NOT just the label
2. UNIQUE risks, strengths, and needs related to NONSEXUAL issues
3. LEAST restrictive setting possible for adolescent—while ensuring needs of victim/society
4. BEST-PRACTICE standards of care
5. RE-ASSESSMENT

Continuum of living arrangements

- Immediate family
- Extended family
- Family friends
- Foster care
- Temporary respite care
- Group home (specialized/general)
- Treatment center (specialized/general)
- Custody (specialized/general)

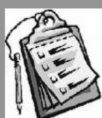


Treatment intensity?

- No sexual-offense-specific treatment
- Limited sexual-offense-specific treatment
- Intensive sexual-offense-specific treatment
- Aftercare / Booster treatment

Common treatment goals…
NOT necessarily for **all** adolescents

- Developing sexual-offense-prevention plans
- Enhancing family communication/relationships (if needed)
- Treating childhood trauma (if needed)
- Enhancing social relationships/intimacy (if needed)
- Altering attitudes supportive of assault (if needed)
- Increasing accountability for sexual offenses (if needed)



Common treatment goals…
NOT necessarily for **all** adolescents
cont.

- Altering deviant sexual interests/enhancing healthy sexual interests (if needed)
- Developing a support network (if needed)
- Enhancing affective expression/regulation (if needed)
- Enhancing awareness of victim impact/restitution (if needed)
- Enhancing self-esteem (if needed)