NEARI NEWS:

TRANSLATING RESEARCH INTO PRACTICE

An Essential Tool for Professionals Working with those who Sexually Abuse or…A Great New Way to Stay Current with Cutting Edge Sexual Abuse Research.

Volume 4, Issue 10 **October 2011**

Dear Colleague,

Our pilot test of a NEARI Press Webinar series was incredibly successful, in large part because of you. Over 500 people signed up for the first webinar with David Prescott, *Best Practice on the Front Lines: What Works With Adolescents Who Have Sexually Abused*. And nearly 300 people signed up for our second webinar with Joann Schladale, *Successful Foundations: Promoting Safety, Family Empowerment, Health and Well Being after Sexual Harm by Youth*.

If you missed either webinar, you can view them on the NEARI Press website at www.nearipress.org, under NEARI Press Resources. We also have some additional resources from Joann and David posted on the website along with each webinar.

Because of the overwhelming response, we could not get to all of your excellent questions so we asked David Prescott (this month) and Joann Schladale (next month) to answer a few more of your questions.

We hope that you have taken advantage of these new FREE learning opportunities from NEARI Press. For us, these are new avenues for us to meet our mission of bringing current information to the broader field of professionals who care deeply about stopping sexual violence.

As always, if you have any

Assessing Risk with the "ERASOR"

by Steven Bengis, David S. Prescott, and Joan Tabachnick

Question
How accurate is the use of clinical judgment, total ERASOR score, and the number of risk factors present in predicting risk of sexual recidivism in adolescents?

The Research
191 male adolescents between the ages of 12 and 19 were assessed by graduate-level practicing clinicians using the ERASOR. All of the youth in the study had been convicted of and/or acknowledged criminal sexual behavior and were receiving treatment in one of five agencies in southern Ontario, Canada. Unlike previous recidivism studies that relied on historical record review for their results, this study used prospective methodology and followed its participants for a period ranging from one month to nearly eight years collecting recidivism data from three sources to increase accuracy.

While acknowledging the study's limitations, the authors indicated the following study outcomes:

- When using either total ERASOR scores and/or the number of risk factors present, the ERASOR predicted sexual recidivism in both long and short term follow-up;
- With a shorter period of 1.4 years, clinical judgment based on the ERASOR results was also predictive; and
- The research indicated that five dynamic risk factors were signficantly related to sexual recidivism including: obsessive sexual interests/preoccupation with sexual thoughts; antisocial interpersonal orientation; lack of intimate peer relationships/social isolation; interpersonal aggression; and problematic parent-child relationships/parental rejection.

Implications for Professionals
In an age of declining resources and profound social consequences to those who sexually abuse, it is more important than ever to focus our most intensive supervision and treatment interventions on those who are at highest risk to reoffend. Empirically based risk assessment tools (like the ERASOR, the J-SOAP-II, the J-SORRAT-II, and the MIDSA), offer us the opportunity to more accurately assess the adolescents in our care. However, as we have written previously, it is vital that professionals do not confuse risk assessment with comprehensive assessments that guide assessment and treatment.

questions, please don't hesitate to contact us at info@nearipress.org or call us at 413-540-0712 x14.

Sincerely,

Joan Tabachnick and Steven Bengis

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FEATURED NEARI RESOURCE

Intellectual Disability and Problems in Sexual Behaviour: Assessment, Treatment, and Promotion of Healthy Sexuality

by Robin J. Wilson, Ph.D., ABPP and Michele Burns, B.Sc

Working with anyone who engages in sexually inappropriate and/or offending behavior is challenging. When the individual has an intellectual disability, the challenge not only increases, it is altered. The goal of this guidebook is to provide the essential knowledge, tools, and perspective necessary for anyone choosing to work with this population. Whether you are a family member, direct care staff, probation/parole officer or a professional creating service plans or providing ongoing support, this manual will help increase your comfort and your understanding of the unique issues of this population.

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Unlike much of the earlier research, this study examined the total score of the ERASOR, the number of risk factors present and clinical judgments of risk, an important comparison. The conclusion is that clinicians do better making short-term judgments. Thus, clinicians need to be very careful to limit predictive statements based on clinical judgment to shorter time frames, and reassess youth routinely.

This study adds to our growing confidence that, used properly (e.g., not as a stand-alone instrument), the ERASOR and other tools can be used to guide risk assessment. Important to note is that the study points out that none of these scales currently examine the impact of protective factors on recidivism. It is critical that clinicians keep abreast of the current research and apply that information to creating more comprehensive risk assessments, treatment plans, goal setting, and safety plans for each individual adolescent.

Implications for the Field
As the field of sexual re-offense risk assessment develops, researchers are beginning to coalesce around a set of dynamic risk factors that appear to have the strongest predictive validity (aggression, substance abuse, antisocial behaviors, social isolation, and lack of parental involvement). But even in this small sample ERASOR study, there are some adolescents in the low to moderate risk category who go on to offend sexually. Teasing out the factors that may lead to that outcome and weighting those factors accordingly may be important. Of even greater importance (and this is noted by the study authors) is the development of strong protective factors. All the study participants were enrolled in "abuse-specific" treatment programs. How do these programs impact on outcomes, with what specific interventions, relationships, and modalities and how do these modalities need to be modified for different adolescents to ensure a better outcome?

The field has evolved significantly from its earliest years when, in the absence of solid research, a clinician's subjective opinion about risk was the only option. Today, our work with adolescents is guided by an increasing amount of risk research. Even with this research, the authors offer an important caution:
...although there is often an expectation that risk assessments should be able to pinpoint the exact probability of a reoffense, the accuracy of current risk assessment tools for both sexual and non-sexual recidivism--for both adults and adolescents--is such that precise probabilistic estmates that are generalizable across various populations are not yet possible.....it might also be prudent, therefore, for professionals in the field to continue to educate consumers of risk assessments about the scientific limitations of these tools.

We could not agree more.

Abstract
Data from the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR; Worling & Curwen) were collected for a sample of 191 adolescent males who had offended sexually. Adolescents were aged 12 to 19 years (M = 15.34; SD = 1.53) at the time of their participation in a comprehensive assessment. The ERASOR was completed by 1 of 22 clinicians immediately following each assessment. Forty-five adolescents were independently rated by pairs of clinicians, and significant interrater agreement was found for the ERASOR risk factors, the clinical judgment ratings (low, moderate, or high), and a total score. Recidivism data (criminal charges) were subsequently collected from three sources that spanned a follow-up period between 0.1 and 7.9 years (M = 3.66; SD = 2.08). Overall, 9.4% (18 of 191) of the adolescents were charged with a subsequent sexual offense over this time period. A

Questions/Feedback

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If at any time you no longer want the e-newsletter, just let us know and we will remove your name from our list.

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About the Editor:
David S. Prescott, LICSW

David Prescott website

An internationally recognized expert in the field of sexual abuse assessment, treatment, management, and prevention, Mr. Prescott has published numerous articles and authored, edited, and co-edited books on risk assessment, interviewing, and providing residential treatment to youth. He is a Past President of ATSA and is currently Clinical Director for the Becket Programs of Maine, overseeing inpatient and outpatient services for juveniles.

shorter follow-up interval of up to 2.5 years (M = 1.4; SD = 0.71) was also examined. Recidivism data for the shorter follow-up interval were available for a subgroup of 70 adolescents, with a comparable recidivism rate of 8.6% (6 of 70). Clinical judgment ratings, the total score, and the sum of risk factors rated as present were significantly predictive of sexual reoffending for the short follow-up period. The total score and the sum of risk factors were predictive of sexual reoffending over the entire follow-up interval. These results add to the emerging research supporting the reliability and validity of structured risk assessment tools for adolescent sexual recidivism.

Citation

- Worling, J.R. Bookalam, D., & Litteljohn, A. (2011). Prospective Validity of the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR). *Sexual Abuse: A Journal of Research and Treatment. Advance Online Publication*, 1-21. doi: 10.1177/1079063211407080.

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Webinar: Q&A

with David Prescott

We received a number of fabulous questions during the webinar. Of course, with only one hour, it is impossible to cover them all. Just the same, we've clustered a number of them into two general categories, and I thought I would take a brief stab at answering them here:

1. What is the effect of past sexual victimization on risk?

This question has been the source of controversy. In fact, entire articles have been written about it. Instruments such as the ERASOR do not include it as a factor, while others, such as the JSORRAT-II do. There are two areas of interest to me in assessing risk as I consider the role of victimization in a young person's life. The first is whether the victimization was a one-time event or a longer series of experiences. The other is what meaning the adolescent has made of the experience. For example, did the experience occur in an otherwise beneficial relationship such that the adolescent has come to believe that sex with much-younger children is acceptable? Likewise, if a young man watches his father assault his mother and understands this as acceptable treatment of women, this belief may place him at risk for continued aggression without treatment. David Burton has done some interesting research in this area (one review of his work can be found in the NEARI Newsletter archives [see June 2008 issue]).

2. Is residential treatment needed for adolescents in certain situations? If so, when?

This is an excellent question! Years ago, placement in residential treatment was the norm. Now it is the exception and not the rule. The available evidence is clear (e.g., the Surgeon General's 2001 report on youth violence) that on its own residential treatment is not effective. This is likely because of the lack of continuity of care between so many programs and community providers. The skills acquired in a residential program often simply don't transfer to the community without extensive collaboration by adults. Obviously, the safety of any victims is of paramount concern and can often be met without placement in a residential program (e.g., via foster care and kinship situations). Increasingly, residential programs seem to be used when the adolescent's behavior or psychiatric conditions prevent less restrictive alternatives. That is likely as it should be. Residential treatment can then be a venue for stabilization and beginning a course of treatment rather than the treatment

itself.

It's also important to note that there are an increasing number of community-based alternatives, such as multi-systemic treatment for adolescents with problem sexual behaviors and teaching family foster care. With these approaches, many have come to view residential treatment as an option of last resort.

Look for information about future webinars in the Spring.